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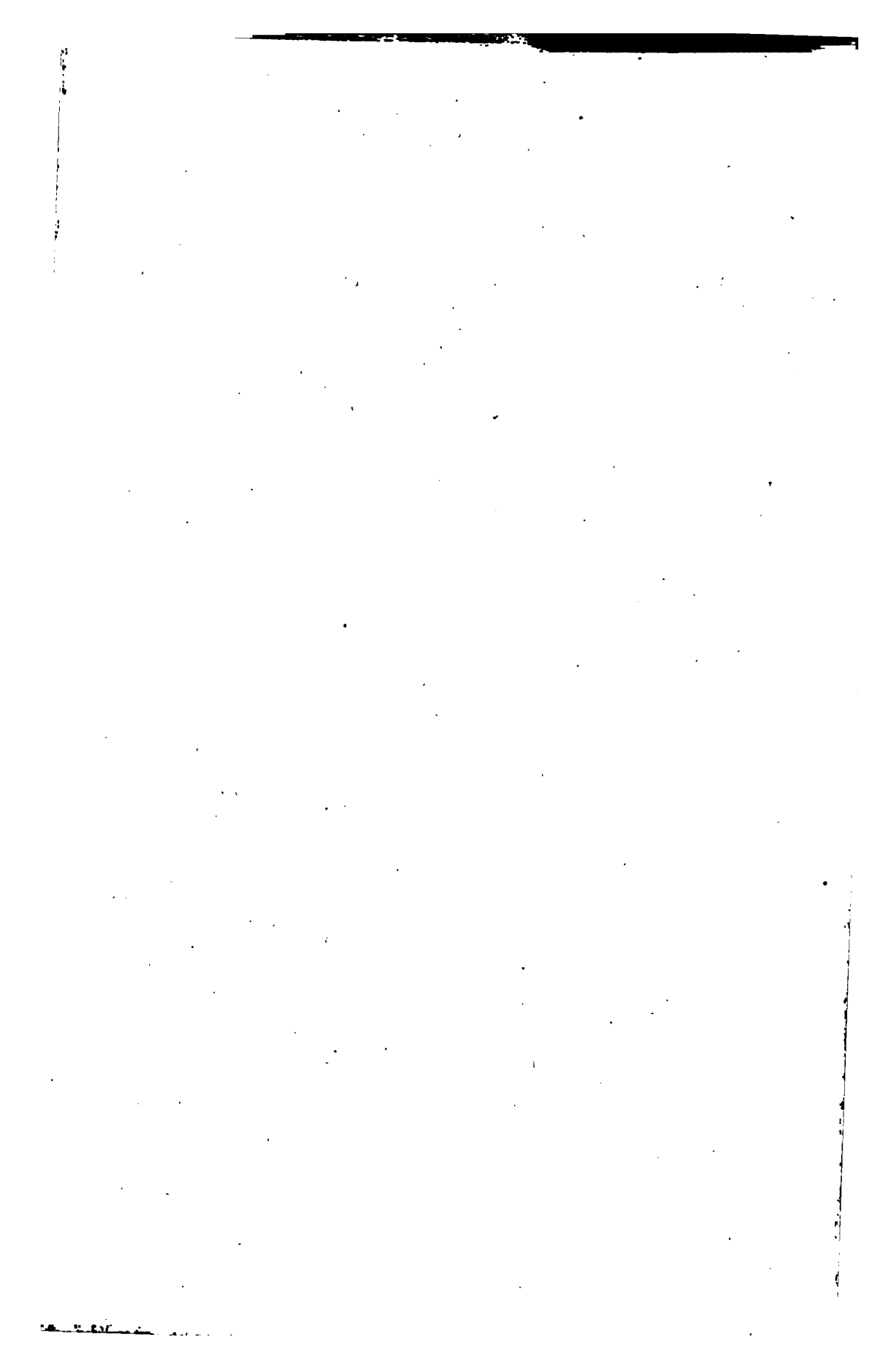
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MR JOHN CAHILL'S CASE OF
TUBERCULOUS LYMPHANGITIS

THE BRITISH JOURNAL OF DERMATOLOGY.

JANUARY, 1895.

A CASE OF TUBERCULOUS LYMPHANGITIS.

BY JOHN CAHILL, F.R.C.S.,

Surgeon to St. John and St. Elizabeth's Hospital.

WITH REMARKS BY J. J. PRINGLE.

THE accompanying drawing illustrates a form of skin affection which is seldom seen upon so extensive a scale, and under such circumstances as in the present case. The drawing represents the left foot and leg of A. H., a woman of 52 years of age. The patient is a single woman, and states that, with the exception of the malady now under discussion, she has always enjoyed very good health, has never within her recollection suffered from any previous illness, and has led an active and hard-working life. Of her family she reports that her father and mother were both very healthy people, both lived to beyond eighty years of age, and both died of "old age," as she supposes. Her brothers and sisters are all healthy and active people. The patient is a straightforward and intelligent person, and she gives a very clear and distinct account of the onset and progress of her present disease.

She states that about twelve years ago she first became aware of a small, rough and tender spot at the point of the left heel, *i.e.*, at that part of the heel which rests upon the bed when the patient is lying flat upon her back with the legs extended. She describes this part of the skin as having been occupied by a "corn" of about the size of a sixpence. For a long time this corn did not increase in size, and

caused the patient no trouble, except that at times it would become excoriated and painful from friction within the boot. A. H. is certain that she had this corn or warty condition of the skin on the heel for fully five years before any further development occurred. At the end of that time, *i.e.*, six or seven years ago, there began to form at the heel, and first in the situation of the corn above described, those fleshy nodular masses upon the skin which are well shown in the drawing. The extension of this disease of the skin then became continuous, with varying rates of invasion. From the heel the disease spread upwards along the back of the leg, and then the skin over the instep became affected. The extent of the disease has increased very much within the last two years.

About five years ago, *i.e.*, some two years, more or less, after the disease began to spread over the skin of the left foot and leg, the patient first noticed a swelling over the metacarpo-phalangeal joint of the right forefinger. There subsequently ensued ulceration of the skin of this finger and of the back of the hand. The disease, which was ulcerative rather than hypertrophic in this situation, gradually involved the skin over the back of the right hand and wrist, and the index-finger became stiffened and useless.

There has never been much pain associated with the disease, either of the foot or the hand, and the patient has only gradually become incapacitated for her work as a domestic servant.

The present condition of the left foot and leg is well shown in the accompanying drawing by Mrs. Toogood Hill. The foot and ankle are swollen, and in a state of unyielding, brawny cedema. The skin disease presents the appearance of irregular nodular masses of a deep red colour and of firm and elastic consistence, which are grouped together in patches. Of these patches the most prominent and the best marked are those at the heel and upon the instep. There are similar patches of disease on the dorsum of the foot, along the front of the leg as high as the knee, and extending irregularly up the back of the leg. Between the diseased patches are small areas of skin of apparently a healthy character. On the heel and at the instep the surface of the diseased skin is in places ulcerated and ragged, and there exudes an ichorous discharge, which is apt to become offensive unless the limb is frequently dressed with a deodorizing lotion.

The right hand presents two small sinuses on the back and two on

the palmar surface, leading down to the metacarpo-phalangeal joint of the index-finger, where the joint surfaces are roughened and exposed. The skin of the index-finger is greatly thickened, and in places ulcerated. There are several small indolent ulcers upon the back of the hand, and an elongated ulcer upon the wrist. About two inches above the elbow-joint and on the inner aspect of the left arm is a hard subcutaneous mass about the size of a walnut, freely moveable under the skin.

On the left knee, just internal to the patella, is a small pit-like depression of the skin, the integument in this situation being apparently quite healthy. The patient states quite positively that this cicatrix-like mark is the result of an accident which occurred when she was 18 years of age, and of which she gives a clear account.

There is no affection of the skin or of the joints in any other part of the body. There is no sign of any disease of the lungs or other viscera.

The appearance of the skin disease of this woman's leg and foot, and of the joint and skin disease of her hand, is quite characteristic of a hypertrophic form of lupus, or at least of a tubercular disease of the skin of a lupoid character, with tubercular joint affection. The results of histological examination likewise confirm the opinion which is so strongly suggested by the appearance of the case.

A portion of one of the large and not ulcerated nodules upon the skin of the woman's leg was sent to Dr. Charles Slater, who reports as follows:—"There is some proliferation and overgrowth of the epithelium, such as might be produced by chronic irritation. The dermis and subcutaneous tissue also show signs of slight inflammation, together with nodules of small-celled infiltration. Associated with these nodules are well-marked giant cells. An examination of many sections for tubercle bacilli was unsuccessful. I am of opinion that the tissue is from a case of lupus."

As Dr. Slater further pointed out, it is not usual to find the bacillus of Koch in lupoid tissue which is of old formation.

This case was exhibited at the first Congress of the Dermatological Society of Great Britain and Ireland, held in London on May 30th last, and it excited considerable interest among those who saw it there, both on account of the unusual character and extent of the disease and the peculiar circumstances of the case. There appears to be little room

for doubt that the disease of the leg and hand is of a tuberculous nature. It is an unusual circumstance that this tuberculous affection should have arisen at the age of 47 years in a woman who presents no sign or history of any previous tuberculous disease, whose health has always been particularly good, and whose parents and near relatives are clearly free from any constitutional taint. The onset of the disease is also suggestive. It commenced in a part of the skin which had been for many years a source of annoyance to the patient from mechanical irritation and the soreness produced by the rubbing of her boot. The late period of life at which the disease began, the history of the broken and troublesome corn on the left heel which had annoyed the patient for so long, and the undoubted fact that the disease originated in the position of this corn and slowly spread to the surrounding skin from that centre, are facts which can only be satisfactorily explained upon the hypothesis that we have here a case of tubercular disease resulting from direct inoculation. By what agency the "materies morbi" may have been conveyed to the sore heel it is now impossible to say, although numerous sources of such conveyance can be readily supposed.

That, however, the tubercular poison was directly introduced at the woman's heel, that the skin disease of the whole foot and leg arose by extension from the point of inoculation, and that the disease of the patient's hand was a subsequent result of general constitutional infection originating in this way, appear to be the conclusions warranted by a study of the case.

REMARKS BY J. J. PRINGLE.

With the observations of Mr. Cahill I heartily concur, admitting merely some reserve as to the desirability of applying the term "lupus" to a case which differs so materially in many respects from the usual clinical conception of that form of tubercular disease of the skin.

I am also inclined to suspect that the so-called "corn" may have been of tubercular origin, indeed, may have been an example of *tuberculosis verrucosa cutis*, which had remained passive for many years before constitutional infection set in. I have comparatively recently had the opportunity of seeing an indubitable example of

general tubercular infection in a young medical man from a *verruca necrogenica* of the usual chronic type, of three or four years' standing.

I entirely share Mr. Cahill's view as to the impossibility of tracing the entrance of the tubercle bacillus in many cases of inoculated tuberculosis.

I am indebted for the honour of being asked by Mr. Cahill to contribute some remarks upon his case to the fact, that at the meeting at which the patient was exhibited I ventured to express the opinion that it was an example of the condition known in Paris under the name of "Lymphangite Tuberculeuse," with the models of which in the Saint Louis Hospital Museum I was familiar. A comparatively recent visit to that city has confirmed the accuracy of the observation, and through the kindness of Monsieur Feulard I was able to obtain access to the notes of an unpublished example, formerly under the care of that indefatigable recorder of facts, the late regretted Dr. Lailler.

The number of models in the Museum illustrating the condition is fifteen, taken from nine patients. These I shall pass in rapid review, with observations made from a study of the models, merely premising that they are all probably examples of the same morbid condition with minor details of clinical difference.

CASE 1.—One model; under the care of Bazin in 1870, No. in catalogue 185, labelled in 1870 "*Lymphite Valvulaire*," renamed in 1889, "*Tuberculose cutanée, lymphangite*": a right hand and arm showing confluent tubercular ulceration on the outer side of the dorsum of the hand and scattered, large, prominent, tubercular nodules or gummata along the course of the lymphatics. Not much elephantiasic enlargement indicated.

CASE 2.—Three models; under the care of Guibout in 1878, of Lailler in 1875 and 1876; labelled in first instance "*Varices lymphatiques ulcérées*," and renamed in 1889 "*Pachydermie lymphangi-ectasique de Rindfleisch*": considerable elephantiasic enlargement of the posterior part of the left foot, ankle, and lower third of the leg, which are studded with large, bossy, purplish prominences and some big semi-translucent beads of (?) lymph on the summits. A few show some ulceration very like tuberculosis. There is not much hypertrophy outside the affected part. There is no note extant of Guibout's description of the case in 1878, except of the diagnosis "*scrofulides fongueuses de l'articulation tibio-tarsienne gauche*," but the following brief abstract of Laillier's full observation are of interest:—

The patient was a clog-maker, aged 88, who in 1868 contracted syphilis, but was pronounced cured after eight months vigorous treatment by mercurial injection in the Hôpital du Midi. In 1869 he received a wound on the left leg, which took three months to heal. In 1870 he got an injury in the same spot, just above the external malleolus, which slowly cicatrized, but ulcerated again spontaneously in

1871, and persisted and with several feeble attempts at recovery till 1878, when the first model was taken. He improved remarkably under compression with elastic bandages, but returned in 1875 with considerable extension in all directions. On October 10th, 1875, it was noted:—

"There is marked atrophy of the left lower extremity with marked thickening of the integument of the left thigh and leg, where hair is much more abundant and silky than on the right side. Tubercular prominences of violaceous colour are present over the affected part. The left foot is fixed at a right angle with the leg, apparently as the result solely of the cicatricial contraction of the skin, which is cedematous and chronically inflamed, the ankle, tarsal and metatarsal regions being all diffusely swollen. From the junction of the lower third with the upper two-thirds of the metatarsal region the skin presents a cicatricial aspect like mother-of-pearl, and there are upon it a large number of prominent nodosities, conspicuous owing to their reddish-violet colour; some of these are isolated, but for the most part they coalesce to form tumours resembling certain phleboliths. The tendo achilles region is occupied by veritable tubercles the size of half a pea, arranged in lines, from which when deeply pricked a lactescent fluid exudes. The outer side of the ankle is studded with abrupt projections slightly fluctuating and reducible by pressure. Over the dorsum of the foot the skin is irregularly bossy and of reddish-violet colour. The bosses, like those of scrofula, are softish, fluctuate imperfectly, and are partially reducible by pressure, and yield on superficial puncture blood, but on deep puncture a lactescent fluid. The borders of the diseased area are continuous with smooth, shiny, glistening skin, with delicate bright vascular ramifications. The patient states that all the parts of cicatricial appearance were formerly tuberculous, and that peripheral extension occurred with central healing. There is no venous blocking or varicosity, but some enlarged glands in the groin and (?) agglomerated lymphatic glands in Scarpa's triangle."

The case is open to the grave and obvious objection that it may have been an instance of elephantiasis and lymphangitis associated with tertiary syphilis, a subject recently discussed with marked ability by Dr. Francis in this Journal, but it is scarcely likely that so experienced and skilled an observer as Lailier would fall into such an error. Although the word "scrofula" is used throughout the observation in the loose manner then prevalent in France, my study of the model strongly inclines me to accept the recent St. Louis view of the diagnosis even in the absence of positive proof of its tuberculous nature. I have under observation at present a case to which much of Lailier's description would accurately apply, which is certainly not syphilitic, and almost certainly tuberculous.

A curious point in connection with Lailier's case, however, and one inexplicable to my mind from either the syphilitic or the tuberculous view of its origin is, that the patient was cured by continuous firm compression by flannel bandages for eight months, under which scabs

formed, which, when detached, left smooth skin. The last model illustrates the case when cured.

CASE 3.—One model of a case under Besnier in 1876, labelled "*Varices lymphatiques de la peau; tumeurs cutanées lymphatiques*," shows the outer side of the left foot exhibiting redness, lymphatic vesicles, ulceration of decidedly tuberculous aspect, and elephantiasis strongly suggestive of the type of tuberculous disease under discussion—but positive proof of its nature is wanting, and I am not aware that the case has been fully worked out or published.

No further details of the case could be obtained, but I entertained no doubt as to its nature.

CASE 4.—Two models of a case under Vidal, designated in 1890 "*Lupus ulcéreux éléphantiasique*," and in 1890 "*Tuberculose cutanée*," on the left foot, the last four toes destroyed by ulceration, with marked elephantiasis of foot and leg, and lymphangitic pink blush and lymphatic varices over both. No bossy prominences are noticeable, but a condition of the outer side of the ankle described as "*ichtyose secondaire, serpentine et cornée, localisée*" appears to me to be a verrucose tuberculosis.

CASE 5.—Two models of a case under Lailler in 1879 and 1894, labelled "*Tuberculose cutanée, varices lymphatiques ulcérées*." The right foot and leg and lower third of the thigh exhibits considerable elephantiasic enlargement, numerous large bossy prominences with beads of thin pus at the summits of many, deep ulceration and scarring, and centrifugal satellitic extension. The later model shows the further progress of the disease.

CASE 6.—Two models of a case under Merklen in 1885, labelled "*Tuberculose cutanée, lymphangite tuberculo-gommeuse*." The first model shows the right arm and left hand (together) which exhibit ulcerating bossy lesions arranged in lines with eczematoid patches over the terminal phalanx of the middle finger. The second model shows the palmar surface of the left hand.

From the evidence before me I was unable to form any decided conclusion as to the nature of this case, and further details were wanting. I am not aware whether the case has been published.

CASE 7.—One model of the forearm and hand of a child, observed by Hallopeau in 1887, labelled "*Tuberculose cutanée; lymphangite, gommés ulcérées*."

The "gummata" are not arranged in a manner strongly suggestive of lymphatic implication, and the evidence of lymphangitis on other grounds does not seem very strong; there is no elephantiasis.

CASE 8.—Two admirable models of the left foot and leg, a case under Hallopeau in 1890, labelled "*Lymphangiectasie suppurative d'origine tuberculeuse*,"* show

* Published in detail in *Ann. de Derm. et Syph.*, 1890, p. 957, and *Bull. Soc. Derm. et Syph.*, 1890, pp. 175, 205, 207; 1891, pp. 89.

the left foot and leg with great hypertrophy and pink blush in ill-defined rings. Typical violaceous bosses, with some central ulceration, are present.

For details and points proving the tubercular nature of the disease reference must be made to the published accounts of the case.

CASE 9.—Left hand and arm of a case—not yet catalogued—observed by Thibierge in 1894, labelled "*Lymphangite gommeuse ; tuberculose consécutive à une dactylite tuberculeuse.*" The extremity of the ring-finger is destroyed by tubercular ulceration, the stump being enormously hypertrophied and studded with little lymphatic prominences. The back of the hand is pinkish, with bossy prominences over the metatarsus and back of forearm, some ulcerating. Inoculation experiments proved the tubercular nature of the lesions. The patient was a man, aged 82, who suffered from suppurating glands in the neck at the age of 20. An injury to the affected finger preceded its tubercular manifestation.

The main object of these remarks is to point out that Mr. Cahill's case belongs to an acknowledged type of tuberculous affection of the skin characterized by the presence of large prominent bosses, frequently of pinkish or violaceous colour, with involvement and blocking of the lymphatics and consequent brawny œdema and elephantiasis of the affected part. The condition is certainly an extremely rare one, and I have seen only one case approaching it in character, already referred to in the text, which has been a puzzle to the most experienced dermatologists in London during the past six years. Further evidence of its rarity may be adduced by the fact that probably all the examples of it among the enormous wealth of the St. Louis material have been perpetuated by Monsieur Baretta's plastic art, and in all, these number but nine. Monsieur Hallopeau's paper may be regarded as the classic one on the subject, and we have adopted the designation he gives the condition without waiting to inquire into its convenience ;—of its accuracy from the anatomical and pathological point of view there can be no doubt. The object of these remarks will be fulfilled if, by attention being drawn to the subject, new cases are recognized and brought forward, and new facts are elicited.

THE HISTOLOGY OF EPIDEMIC DERMATITIS.

BY EMILIO ECHEVERRIA, M.D.,

Costa Rica.

From Dr. Unna's Dermatological Laboratory, Hamburg.

It has been my privilege to study, under the supervision of Dr. Unna, the histological aspect of the epidemic skin disease which appeared in London during the year 1891, and which has been so ably described by Dr. Thomas Savill, who observed the greater part of those who were attacked by it, and studied its ætiology.*

Pieces of skin from two of the fatal cases were removed before decomposition was advanced, although the post-mortem was held nineteen hours in one, and thirty-six hours after death in the other case.

The tissues were placed in a 50 per cent. methyl alcohol and water, the fluid was changed at the end of one week, and then again from time to time; and in that way they were preserved since August 1891 until they were sent for examination.

Sections were made in the usual way, and stained by the following methods:—

(a.) *Methylene-blue Orceine*.—(1.) Place section directly from alcohol in Unna's Polychrom Methylene-blue and leave it there for two or five minutes. (2.) Wash well in water. (3.) Place section in neutral orceine (Grübler) solution ($\frac{1}{4}$ per cent. in absolute alcohol) from two to five minutes. (4.) Wash in 80 per cent. alcohol, to which an equal part of æther may be added to remove celloidin when abundant. (5.) Clean in bergamot oil and mount in xylol balsam.

(b.) *Hæmatoxylin and Acid Orceine Method*.—(1.) Sections should be placed in a small dish containing enough acid-orceine solution to com-

* *British Journal of Dermatology*, February and March, 1892; and *Monatshäfte für Praktische Dermatologie*, Band XV., 1892.

pletely cover them. (This is a 2 per cent. solution in 1 per cent. HCl and absolute alcohol.) (2.) Place this dish on a previously warmed slide and heat the whole gently, by placing a spirit-lamp about four inches underneath it. Keep up this heat until the solution becomes of a thick jelly consistency. (3.) Wash well in 60 to 80 per cent. alcohol. (4.) Wash in water. (5.) Place it in aqueous solution of hæmatoxylin for ten to fifteen minutes. (6.) Wash in water. (7.) Wash in 80 per cent. alcohol, or still better in 1 per cent. HCl alcohol :—oil of bergamot and balsam.

(c.) *Carminé Gentian Iodide Method*.—(1.) Place section in water to remove alcohol. (2.) In 2 per cent. alum and cochineal solution for two to five minutes. (3.) Wash in water. (4.) Gentian solution, five minutes. (Water and anilin oil are mixed until a milky suspension is obtained, filter it through previously moistened paper and mix it with equal parts of filtered strong spirituous gentian sol.) (5.) Wash in water. (6.) Place section on the slide and spread it out. (7.) Cover section with 1 per cent. aqueous solution of iodide of potassium, to which H_2O_2 has been gradually added, until a rich lemon-yellow colour is obtained; this should bathe section for two to three minutes. (8.) Remove excess and then dry section as well as possible by pressing it with the blotter. (9.) Decolourize with anilin oil. (10.) Wash in xylol and mount in balsam.

These methods answered very well for the staining of cell bodies, elastine, and so forth, but the nuclei did not give a desirable picture, and it was found advisable to stain them by the so-called *methylene-blue-acid fuchsin* (a) and by the *watery-blue-saffranin method* (b), their technique being as follows :—

(a) (1.) Place section from alcohol in methyleneblue solution (polychrom), and leave it there fifteen minutes. (2.) Wash in water. (3.) 99½ per cent. tannic acid aq. sol. for one or two minutes. (4.) 2 per cent. acid fuchsin aq. sol. two to three minutes. Wash in water, alcohol, oil of bergamot, and mount in balsam.

(b) (1.) Wash section in water. (2.) Place it in a 2 per cent. aq. sol. of waterblue for two or three minutes. (3.) Wash in water. (4.) 1 per cent. aq. sol. of saffranin for five minutes, then alcohol, oil of bergamot and balsam.

By examining tissues treated in these ways a very fair idea of the pathological changes in the skin can be formed, for every method

tends to bring out a special histological portion of it—this not being possible by any single method of staining.

This disease has a few analogies to eczema, both clinically and histologically, but it has in both respects more points of difference than of similarity.

Histologically these points of resemblance are:—1st. That both affections are superficial—that is to say, affecting chiefly the epidermis in all its layers and the papillary layer, but diminishing greatly towards the depth of the skin; notwithstanding that the deepest layers of it are also, to a certain extent, involved.

2nd. That there exists in both diseases a scaliness of the surface, which forms a special feature of both, and is histologically manifested by loose horny layers, attached to the surface, and more or less changed into scales and crusts.

3rd. That we meet with a decided hypertrophy of the prickle layer.

4th. That in most sections of both diseases the keratohyalin, forming the special substance of the granular layer of the epidermis, has disappeared in epidemic dermatitis in a more extensive manner than in chronic eczema, where the disappearance of keratohyalin is, in most cases, limited to certain parts, and only in the so-called *eczema rubrum* extends over the whole surface, as it does here. This disappearance of keratohyalin from the middle layer of the epidermis stamps the whole process as belonging to the group called parakeratosis, viz., dry catarrhs of the skin.

5th. That there is a considerable amount of cell infiltration in the cutis, mostly by enlargement of the previously existing cells and by mitotic cell proliferation, i.e., by karyokinesis.

The differences, however, are far greater, and are as follows:—

(1.) At a first glance the expert will notice that the relations between papillary and interpapillary layers is diametrically opposed in these two affections. In the epidemic disease the interpapillary prolongations are narrow, and the papillæ quite swollen; while in most cases of eczema the papillæ are elongated but narrow, and the interpapillary prolongations are very broad.

(2.) The granular layer is not to be seen in either case. In chronic eczema the prickle layer gradually blends into the horny one, so that there exists a uniform epidermal covering, without the usual separation into three layers.

In the epidemic disease, on the other hand, the middle layer of the epidermis, having lost its keratohyalin, forms with the uppermost portion of the prickle mass, and the remaining horny layer, *one new clear* layer extending over the rest of the prickle layer. Thus, in this disease, instead of the old three-fold normal epidermis a new pathological two-fold one is developed.

(3.) In eczema the protoplasm of the prickle cells is equally enlarged throughout the whole layer. This is not the case in the epidemic disease, where there is no enlargement of the lower strata of the prickle layer; but, on the contrary, the lower strata are relatively scanty, so that nothing but closely aggregated nuclei are here apparent, thus explaining the dark coloration of this lower plain in the stained sections. This appearance changes rather sharply in the upper clear layer, where, besides a curious change of the swollen nuclei, about to be described, the protoplasm now also swells, and the whole epidermal cells look, therefore, very translucent, and cannot be well stained.

(4.) The most important change in Epidemic dermatitis is, however, in the nuclei of the prickle cells. In chronic eczema the nuclei are equally and moderately enlarged, showing no unusual change of structure and stain well throughout the entire prickle and horny layers.

In the epidemic disease, on the other hand, the nuclei show remarkable changes in the prickle cells, and this is what forms the most salient point of difference between the two diseases, and is, as I believe, *the specific or pathognomonic histological sign of this new disease*. As just stated, their appearance varies according to the height of the prickle layer in which they are observed. In the *lower strata* their change consists, first, in a general hypertrophy; and, secondly, besides this, in an irregularity of shape, being due to pressure from the papillæ, rendering them more or less spindle-shaped; but their substance does not seem to be modified, as we might infer from their normal and equal capability of staining. In the *upper strata* of the prickle layer the nuclei look at first sight as if shrunk into themselves, leaving a semi-translucent areola-like space around them, its outer border indicating the limit of their former size. Very delicate but easily stained processes may be seen radiating from the remainder of the now more faintly coloured nucleus towards the outer border of this apparently clear space. But a closer

examination of these apparently clear zones around the nuclei shows that they are by no means spaces free from substance, but on the contrary are occupied by a *solid translucent mass*. This substance does not take colour readily, and looks, therefore, in specimens stained with the common hæmatoxylin and carmine dyes, like a hollow around the nucleus.

(a.) On this account it was necessary to have recourse to other dyes, such as methylene-blue and safranin, by which the apparently clear spaces are coloured (in blue or red), and show immediately that here we have to do with a sort of degeneration of the nuclear body—a solid, clear, homogeneous, though not easily stainable substance. The nuclear processes which traverse this substance are, when using these better staining methods, more deeply coloured than the surrounding glassy mass; thus explaining why, in using only hæmatoxylin and carmine, they appear to stain a floating nucleus, attached by processes to the inner border of the protoplasm.

(b.) A *second reason* by which the solidity of the “clear spaces” is easily proved, consists in the not infrequent instances where the entire nucleus, with its degenerated periphery, is a little contracted, and lies in a larger cavity of the cell protoplasm. Here the difference between the cleared-up periphery of the nuclei and the *real* clear space at its side is very apparent to anyone. I have also met with two nuclei in a centre of a cell, the periphery of both proving to consist of translucent material, and both contrasting strongly with the clear angles left between them and the round border of the protoplasm.

(c.) There is yet another distinct feature of this phenomenon which would by no means agree with the hypothesis of a mere shrinking of the nucleus. The shrinking of the cell-nucleus is a very common fact in the pathology of skin diseases, be it—as is mostly the case—only a result of hardening; or—as it is rarely—a true pathological symptom. A shrunken nucleus, under those circumstances, always lies asymmetrically at one side of the cavity of the protoplasm, which has become, as it were, too large for it, either in a roundish state (leaving a semilunar cavity), or in a semilunar form (leaving a roundish cavity). But here, if the change be shrinkage, we should have to do for the first time with a perfectly regular and symmetrical shrinking of the nuclei in all diseased prickly cells, which would be

scarcely explainable by the common causes which induce shrinking.

(d.) In the light of the foregoing explanation, we understand, moreover, the real nature of those curious processes, radiating from the undegenerated remains of the nucleus outwards. They are nothing else but the remains of the nuclear substance, which have escaped this peripheral degeneration.

For all these reasons we come to the conclusion, that this is a *specific degeneration of the nuclei of the prickle layer*, beginning in its upper strata, after a decided hypertrophy of the nuclei had taken place in the deeper strata. This degeneration begins at the outer border of each nucleus and changes the peripheral zone of the latter into a homogeneous, hardly stainable mass. This degenerated outer zone is always traversed by a great number of non-degenerated lines that radiate from the central remaining nuclear mass like the spokes of a wheel. Another remarkable fact is, that the thickness of this glassy zone is nearly the same in the nuclei of every layer, not trespassing beyond a certain limit, so that there always remains a sort of small nucleus of about one-half its original diameter, and this in all the centres of the diseased prickle cells. The remaining portion of the nucleus stains more faintly the higher we ascend in the epidermis, and at last becomes almost invisible, but without joining the glassy degeneration of the peripheral part of the nucleus.

Now what is this glassy mass, occupying the periphery of all nuclei in the epidermis?

The first idea, that we have to deal with a hyaline degeneration in the sense of *von Recklinghausen* proves to be erroneous, because its substance does not stain easily by acid dyes (*e.g.*, acid-fuchsin). On the contrary, in the two last methods quoted it takes the basic colour (*viz.*, the saffranin in the waterblue-saffranin method and the methylene-blue in the methylene-acid fuchsin method). Thus we must conclude, that this substance has more the colouring properties of the normal nuclear substance. It would therefore be advisable to give a proper name to this new sort of degeneration of the nuclei, and I propose to call it the "*Peridiaphania*" of the nuclei. This peridiaphanic degeneration occurs not only in the prickle cells, but it is occasionally found in the cutis, chiefly in those parts of the papillæ which are adjacent to the prickle layer.

(5.) The coil-glands in the epidemic disease show irregularity in the form and shape of their loops, which are sometimes swollen to a considerable extent. The interglandular collagenous tissue shows much œdema and new growth of fibrillæ. This degeneration of the coil-glands does not exist in chronic eczema, though they are often a little swollen, and show some mitosis of the glandular cells. The interglandular collagenous tissue is, however, always healthy.

(6.) The emigration of leucocytes from the blood-vessels does not seem to play any rôle at all in the epidemic process ; while in chronic eczema this local leucocytosis exists to a certain degree, especially in the papillary layers of the cutis, the leucocytes wandering from here to the epidermal surface.

Taking all these facts together, I think we must conclude that:—

(1.) *Epidemic Dermatitis, from a histological standpoint, is a totally different process from chronic eczema.*

(2.) *That it belongs, nevertheless, together with chronic eczema, to a larger group of inflammatory diseases of the skin, which shows hypertrophy and scaling of the epidermis with superficial cell-infiltration in the cutis (i.e., to the group of catarrhs of the skin) ; and among these to the smaller group of parakeratoses (Auspitz-Unna), because the special feature, characterizing the parakeratoses (viz., the loss of keratohyalin in the epidermis), is common to both diseases.*

(3.) *That Epidemic Dermatitis differs from chronic eczema, besides other minor histological features, principally by a remarkable and new sort of degeneration of the nuclei of the prickly layer of the epidermis, viz., the peridiaphania of the nuclei.*

Remarks.—The foregoing researches have a practical bearing of some importance, because, in the first place, they show, by independent histological investigation, that the disease under consideration differs considerably from chronic eczema, a fact which Savill and others have maintained on purely clinical grounds.*

In the second place, the circumstance that the essential histological changes in the epidemic disease are superficial, and to be found

* "On an Epidemic Skin Disease," Savill, London, 1892 (H. K. Lewis), p. 28, and Lees and Stephen Mackenzie (*ib.* p. 37) ; "Diseases of the Skin," by McCall Anderson, 2nd edition, London, 1894, p. 807 ; and *Monatshefte für Praktische Dermatologie von Unna*, Band XV., 1892, and Band XIX., 1894, p. 881.

mainly, or almost entirely, in the epidermis, is also interesting. The cases which were examined in the foregoing pages were extremely severe ones, yet in these, only slight change was found in quite the superficial layers of the derma. Nor is it to be wondered at that, in very severe or prolonged cases, the changes should spread a little to the derma proper. Nevertheless, the disease is essentially a superficial one (an epidermatitis, rather than a dermatitis), a fact which has more recently been insisted upon by Savill on clinical grounds.* It was for this reason he objected to the word dermatitis being used, and I would suggest instead that the word *epidermatitis* should be substituted.

Lastly, the new and distinctive change revealed in the nuclei of the prickle cells, which is different from the histological change found in any skin disease hitherto examined, is, perhaps, the most important point of all. I believe this to be peculiar to, and pathognomonic of, the disease, and if I am correct, we have here a method of identifying the disease which, though perhaps not available in every instance, is at any rate shorter and less troublesome than the crucial test of attempting to obtain, from a case, cultures of a coccus having certain physical and pathogenic properties.

The disease is not difficult to diagnose owing to its invariable features of epidermal desquamation and definite march and duration; but in sporadic instances of the malady it is sometimes hard, owing to the condition having only recently been differentiated, to carry conviction to the minds of others by purely clinical arguments.

* *Monatshefte für Praktische Dermatologie von Unna*, August, 1894, pp. 885-6.

DESCRIPTION OF PLATE.

FIG. 1. (a) Clear middle epithelial layer; (b) dark lower epithelial layer; (c) periglandular enlargement of the coil-glands. Low power.

FIG. 2. (a) Horny layer; (b) middle epithelial layer, showing *peridiaphania* of the nuclei; (c) lower epithelial layer, showing hypertrophied nuclei. Leitz oil immersion, 1,750th.



FIG. 1.

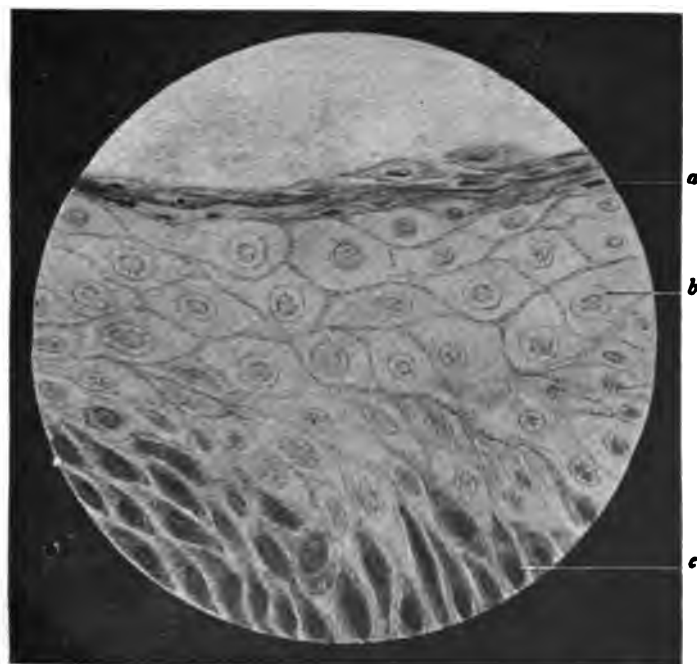


FIG. 2.

REVIEW.

PROF. MCCALL ANDERSON'S TREATISE ON DISEASES OF THE SKIN.*

THE conditions under which the first edition of this work appeared were especially interesting. The author was happy in having received an early special training in diseases of the skin, both in Great Britain and the Continent; in having devoted many years to the study, and in having acquired a very extensive experience of this class of disease; and lastly he was not only a teacher of eminence with the gift of clear exposition, but was likely to regard the subject from a broad point of view as Professor of Clinical Medicine in the University of Glasgow. With these qualifications an unusually interesting treatise was looked for, and the profession was not disappointed. The fact that a second edition has been so soon called for is ample evidence of the reputation of the author and of the appreciation with which the work is regarded.

The treatise has been planned with certain limitations, and is especially devoted to the consideration of the symptomatology, diagnosis, and treatment of diseases of the skin. The author has refrained from loading his pages with histological details, and indeed has carefully avoided the discussion of points which, however interesting, appear devoid of practical utility. The volume is written in the clear direct style familiar to readers of Professor Anderson's memoirs, and is eminently practical both in the scope of the work, in the careful differential diagnoses given, in the directions for treatment, and in the multitude of selected formulæ with which the pages abound. One of the features of value is that the book obviously bears the stamp of the author's individuality, and is a compilation of his own experience. The author belongs rather to the older school of dermatologists, but he was well-grounded in both German and French views. He is distinctly conservative, though quite alive to modern methods of treatment, and readily adopts them when his own experience shows

* *A Treatise on Diseases of the Skin, with special Reference to their Diagnosis and Treatment, including an Analysis of 12,000 consecutive Cases.* By T. McCall Anderson, M.D., Professor of Clinical Medicine in the University of Glasgow. Second Edition. (London: Griffin. 1894.)

him their value. Another feature, which no doubt adds a good deal to the number of pages, is the valuable selection of interesting illustrative cases drawn from the author's well-stocked note-books.

The construction of the work is rather peculiar in that the author has made free use of a number of his memoirs, and consequently there is a certain want of proportion in the handling of the subjects, both as to quantity and quality. For instance, Eczema, Psoriasis, and most of the parasitic diseases from this cause get a relatively fuller treatment, and, considering their frequency and importance, probably this increases the value of the work to the practitioner. But some rare diseases, such as Xeroderma pigmentosum, Moniliform and Banded Hair and Hæmidrosis, come in for special discussion, whilst others, which the author cannot deal with satisfactorily from his own experience, receive but scant notice, as Chromidrosis, or none at all, as Erythrasma. This is a feature of the work which arises from the author making it largely a record of his own experience, but it lessens the value of the book, from another point of view, as a work of reference. Many of the descriptions of common affections are decidedly incomplete. For instance, we will mention Herpes zoster, Pemphigus, and Lichen planus. The description of Pemphigus is rather short, and contains no reference to *P. vegetans* and Köbner's Congenital Pemphigus. Lichen planus crescents and beads and rings are not alluded to, or the acute attacks, the varied degrees of itching, and the modifications in different localities. Moreover, the differential diagnosis is scanty. We think that this is probably intentional on the author's part, as a complete description is perhaps not within the scope of his plan, and possibly the growing bulk of the work necessitated curtailment. Still we repeat the fact, for many who turn to the book will be disappointed in finding a comparatively meagre account of many diseases. Though many bibliographical references are given it is by no means a storehouse of value in this respect. We have also experienced disappointment in missing allusions to much modern work and speculation of value.

To render the treatise as complete as possible Prof. Anderson has obtained the assistance of several valued helpers. Dr. H. C. Cameron has written most of the purely surgical sections, including Sebaceous Cyst, Anthrax, Pustula maligna, Dermatitis calorica, Nævus, and Epithelioma; Dr. William Macewen has undertaken most of the articles on Ulcers; Dr. George A. Turner has added

Elephantiasis, Lymph Scrotum, Framboesia, and looked to a revision of the late Dr. Christie's articles (1st Edition) on Delhi Boil, Parangi, Donda Ndugu, Leprosy, Ainhum, Madura Foot, Pellagra, and Guinea-Worm disease. Some of the late Dr. Christie's articles require further revision to bring them up to date ; for instance, Madura Foot and Guinea-Worm disease. The entrance of this filaria by the skin is a fiction of somewhat old standing. Dr. P. G. Unna contributes a special article on Eczema Seborrhœicum, and Dr. Savill an account of his Dermatitis Exfoliativa Epidemica. Last, but not least, Dr. Brown is to be congratulated on his excellent index. There is an appendix containing an abstract of cases reported in the "International Atlas of Rare Skin Diseases." A number of illustrations, original for the most part, complete this valuable work.

So much for general criticism. In a book of this personal character it is obvious that many statements will be found on which discussion might well arise, and in which the author's and reviewer's experience are not on all-fours. In reading through the pages we have noted a number of points for remark, which may perhaps be alluded to in this Journal.

The classification adopted is a modification of the one promulgated by Dr. A. B. Buchanan. Skin diseases are divided into two great classes : the *Functional*, including affections of the Skin, Hair, Sebaceous glands, and Sudoriparous glands ; and *Organic*, including Inflammations, New Formations and Tumours, Hæmorrhages, and Diseases produced by uniform causes, as parasitic, syphilitic, strumous affections, and eruptive fevers.

We constantly find allusions to the "contraction of a bad habit" on the part of different elements of the skin. It is often a convenient expression to account for the continuance of a disease, but whether it is founded on fact is an interesting matter for debate. Pruritus is a subject very meagrely dealt with, in our opinion, considering the difficulties attending the unravelling of its causes and the consequent successful treatment. Under Atrophy we failed to note any allusion to circumscribed Scleroderma as a cause of Hemiatrophy of the Face, or of the lines of depression going over the forehead from the supra-orbital notch. The author says he has never seen Leucoderma in children, and we are aware that Crocker says it is comparatively rare. In our experience it is not very rare.

Under the heading *Secondary pigmentation* we miss any special description of the pigmentation occurring after Lichen planus, or the administration of arsenic, of Morphœa, Vagabond's disease, and of the Leucoderma of Syphilitics. Even under *Drug Eruptions* there is little said about Arsenical Pigmentation. The description of Alopecia areata strikes us as incomplete and somewhat meagre, considering the great interest the several conditions included under this term have excited in modern times. The histology also is not up to date. We note that the author is familiar with Robinson's Hydrocystoma. The chapter on the Erythemata reminds us of the confusion that still attends the use of the term Erythema. Thus the author uses the term as implying a simple superficial inflammation of the skin, and includes not only Erythema multiforme, but the early and terminating stages of eczema, Pityriasis capitis, which he distinguishes from Seborrhœa sicca capitis, Erythema strophulus, Erythema punctatum (Scarlatiniforme of Hardy), Roseola, Erythema circumscriptum (Lichen circinatus serpiginosus of Wilson), Pityriasis rosea, etc. Herpes iris is included under Erythema multiforme, but described under Herpes, and referred to on page 364 as Hydroa. The etiology of E. multiforme, according to modern views, is very imperfectly given. The long and important section devoted to Eczema contains several points inviting remark. We cannot agree with the author that it is well to retain the name *Lichen*, as designating an eczema, the elementary lesion of which is a papule. Nor can we concur in the propriety of dignifying Eczema rimosum as one of the five varieties of eczema, because *the principal elementary lesion of it is a fissure*. The author in his introductory chapter rightly includes *rimæ* amongst the secondary lesions of the skin. Prof. Anderson does not allude to the parasitic theory of eczema, but perhaps he leaves this theory to be expounded fully by Dr. Unna under Eczema Seborrhœicum. We note the view that "Eczema mercuriale" is never of external origin, and the agreement with Kaposi in calling Impetigo contagiosa a form of eczema. Sycosis also is regarded as a form of pustular eczema. The statement on page 201 that perforation of the septum may occur in Eczema narium attracted our attention as not being within our own experience. We think there is a slip on page 294 in making Pemphigus neonatorum (an epidemic septic or contagious affection) synonymous with the bullous syphilide of infants. So also Sclerema neonatorum is called Scleroderma neonatorum. The statement that

there is a syphilitic and non-syphilitic form of Psoriasis and *Lepra* is a little old-fashioned in form. Nor do we agree that circinate psoriasis is always a mere declining stage ; or, at any rate, there is a remarkable tendency in some cases and some people for a great number of the papules to quickly assume an annulate form, and the same holds good for Pityriasis rosea. The Lichen pilaris here described is apparently the Keratosis pilaris of Crocker, and the author does not describe the very striking but uncommon disease of children called by Crocker Lichen pilaris. The differential diagnosis from follicular Ichthyosis (*Cacotrophia folliculorum* of Tilbury Fox), and Lichen scrofulosorum is not given. We miss also a discussion on the several keratoses of the palms and soles, and a description of the eruptive plane warts of juveniles. Harlequin fœtus is not mentioned, nor is the treatment for the very severe spinous ichthyosis quite adequate. Again, Pick's remarkable demonstration of the inoculability of *Molluscum contagiosum* is lacking. An illustration is given on page 506 of Fibroma of the palms in a rheumatic subject. This is very interesting in connection with the somewhat similar conditions lately described by Crocker and Smith. We object to the statement that "the only disease liable to be mistaken for Vitiligoidea is *Milium*." Surely Urticaria pigmentosa should be mentioned. Purpura tuberculosa will prove an interesting puzzle to the cognoscenti. The elaborate article on Hæmidrosis also will exercise the minds of many. We will venture to express a lurking suspicion that some of the cases were of artificial production. And this reminds us that Feigned Diseases are not discussed.

The author has enjoyed a remarkably large experience of vegetable parasitic diseases, for all, except perhaps Erythrasma, are evidently excessively common in the Glasgow clinique. In nearly 40,000 cases of skin disease *Tinea versicolor* patients form over 1·1 per cent., and *tinea sycosis* 1·5 per cent., being actually more common, according to our calculations, than ordinary ringworm of the scalp. We are glad to note the author's teaching on the production of a "pruriginoid eruption," or the results of scratching, a subject further elaborated in Paris in recent years under the terms Lichenization and Eczematization. To conclude this list of minor criticisms we will call attention to two other points. The disease illustrated on page 685 as a Scrofuloderm is surely the affection known as Neuropathic papilloma, *Nævus papillaris neuroticus*, etc.

T. COLCOTT FOX.

SOCIETY INTELLIGENCE.

DERMATOLOGICAL SOCIETY OF LONDON.

At the Ordinary Meeting of this Society, held on December 12th, Dr. Colcott Fox brought forward an example of *Lichen planus*, with *Pemphigus* supervening under arsenical Treatment. Mrs. Rose K., aged 26, with a baby eight months old, but not suckling, applied for relief on October 8rd, suffering with copious, generalized lichen planus, accompanied by intense subjective sensations of itching and burning. She was anæmic and obviously ill. The papules were quite typical, and existed on the trunk, arms and legs, and on the latter situation were papillomatous in places. In the mouth were some white specks on the buccal mucous membrane. She had lived with her parents in the Enfield marshes. Her mother had been once in Guy's Hospital with "ague," and the daughter has suffered from attacks of shivering with chattering teeth at intervals all her life. The eruption began about six months previously. She was given five-minim doses of liquor arsenicalis with a quinine and iron mixture three times daily. She showed no improvement for the first fortnight, and then the papules began to display signs of involution. The arsenic was gradually increased to eight minims thrice daily.

On November 28th she stated that she had been in bed ill for a week; having been seized with a "chill," which from the symptoms may well have been ague. She was taken ill on November 19th, and on November 21st a crop of perfect, dome-shaped, clear pemphigus bullæ, of all sizes up to a pigeon's egg, appeared under the chin and then on the forearms, and one on the nose. The lichen planus papules were fading fast, leaving stains, and a minute examination proved that the papules did not vesiculate, but that the bullæ arose indiscriminately over areas occupied by lichen planus lesions, as well as in areas free from them. The tongue was coated, and she complained of aching pains down the arms and in the wrists and elbows, and of marked cramps in the fingers.

The administration of arsenic was continued, and on December 12th the clear bullæ were still evolving in greater numbers on the arms, forearms, and on the front and sides of the upper part of the neck. She stated that they had appeared in the mouth. None existed on the trunk and legs. The latter were very deeply stained by the involuted papules. Some lichen planus lesions could still be traced higher up the legs and thighs. There were areas of erythematous infiltration, perhaps left by crops of bullæ, perhaps primary. She stated that she had had three or four shivering attacks lately, and that the finger cramps continued. She felt sick.

The exhibitor asked whether the pemphigoid eruption was to be considered a phenomenon of the lichen planus disease-process, or whether it was due to the administration of arsenic. The patient was certainly well under the influence of arsenic, and there was some evidence of peripheral neuritis, but the distribution of the bullæ perhaps hardly corresponded with such a cause.

Crocker mentions Morrant Baker as having noticed pemphigus-like bullæ in the course of lichen planus. Unna (*Medical Bulletin*, February, 1885, No. 2, vol. vii. p. 145) observed a few large bullæ on the dorsum of the feet during the arsenical treatment of lichen planus, and on page 146 he mentions a case in which vesicles appeared on the face in lichen planus, and another in which papules on the hairy scalp changed to vesicles. Both these vesicular cases were most unusual ones. Kaposi (*Archiv. f. Derm. v. Syph.*, 1892, pp. 342 and 569) met with a generalized erythematobullous eruption arising in the course of a lichen planus, and regarded it as an intense phenomenon of that disease. The subject of arsenic is not even mentioned, though that drug was probably administered. The exhibitor thought there were other like cases on record, but he had not made any wide search.

As to the causation of vesiculation by the internal administration of arsenic there is little doubt that zoster is thus occasioned, and Morrow ("Drug Eruptions," Syd. Soc., Ed. 1893) refers to some vesicular and pustular eruptions. Rasch reports an *Acute generalized erythematobullous dermatitis* arising during the administration of Fowler's Solution (nine drops daily for two days) to a phthisic. The eruption appeared on the hands, feet, knees, breast, back and genitals, and disappeared when the arsenic was discontinued. Rasch quotes

bullous cases by Girdlestone (in psoriasis) and by Winiwarter (on the hands). It is certainly remarkable that such bullous eruptions are so rare, if due to arsenic administration.

DR. PERRY stated that he had observed two cases of bullous eruption arising during the administration of arsenic for lichen planus, and Dr. Pringle had observed a case of severe psoriasis under arsenical treatment, in which the supervention of an acute generalized exfoliative dermatitis—which proved rapidly fatal—was heralded by the appearance of vesicles and blebs at the edge of the psoriasis patches.

DR. COLCOTT FOX also showed a case of *Kerion associated with Microsporon Audouini*. Dr. Colcott Fox exhibited a child with well-marked multiple kerion patches of the scalp. He also showed a microscopical specimen of the hair from the patches, displaying a sheath of spores encasing the hair. He was unable to distinguish this fungus in aspect and size and in the character of the diseased stump from the *Microsporon Audouini*, and for comparison he exhibited (1) the *Microsporon*, which appears to be the common ringworm of the scalp in London; (2) a *Megalosporon* from a case of kerion; (3) a still larger *Megalosporon* from a case of ringworm of the beard, probably caught from a horse.

The exhibitor stated that only that afternoon he had seen an ordinary case of ringworm of the scalp due to *Microsporon*, whilst the brother had obviously been the subject of multiple kerion of the scalp. There were unfortunately, for purposes of comparison, no longer any diseased hairs.

DR. STEPHEN MACKENZIE showed a case of *Psoriasis of the nails associated with end-joint Rheumatism*. The patient, a male, aged 25, came of a psoriatic family. He had suffered from psoriasis vulgaris for twelve years. Five years ago the nails of the hands became affected, beginning in one nail and taking two years to involve the whole of the nails. Following upon the affection of the nails the terminal joints of the fingers became swollen and painful. At the present time all the nails of both hands and most of those of the feet are discoloured, thickened, dry, cracked and brittle. The terminal joints of all the fingers and of several of the toes are much swollen, and somewhat tender. There is ordinary psoriasis of the limbs and scalp.

His work is that of a printer, and his hands are constantly in gelatine and Indian ink. The author has previously seen one or two cases of psoriasis of the nails with "acro-arthritis," and had exhibited one at the Society a few years back. In that case three fingers of each hand had the nails affected with psoriasis, and the arthritis was limited to the fingers of which the nails were implicated. The joint affection was, as in the present case, an osteo-arthritis, and not the "digitorum nodi" of Heberden.

MR. MALCOLM MORRIS showed a boy, aged 5, who has had his present affection for four years. His family history is unknown.

In various positions on the skin are several raised patches of warty appearance, rather dry, and showing no signs of apple-jelly nodules. These have been diagnosed as *Lupus Verrucosus*, and on the finger resemble verruca necrogenica. The patches vary in size from that of a crown to a sixpence. They are found on the ulnar border of the left wrist, and dorsum of the middle finger of the left hand, on the right palm, over the proximal and middle phalanx of middle finger of the right hand, and on the inner side of the left thigh.

At the side of the last-mentioned signs of scarring are present, showing commencing natural cure.

DR. PERRY exhibited a *papular, pustular and infiltrating Scrofulide*. Florence M., æt. 5½ years, a pale-faced child with enlarged glands in the neck, but otherwise presenting no signs of tuberculosis except the cutaneous lesion to be described, was brought to Guy's Hospital for an eruption on the legs.

On the posterior aspect of the right leg, midway between the ankle and the knee, is a dark-red, slightly raised, well-defined area, roughly circular in outline, and measuring an inch and a quarter in diameter. On palpation the skin of the affected part is found to be thickened and infiltrated, and at one point towards the lower border there is a small shallow ulcer which has existed for about a fortnight. The patch is neither tender, irritable, nor painful. On the left leg, at a corresponding situation, but a little nearer to the foot, is a similar but larger infiltration. Here, however, the diseased tissue has broken down, and on its margin are four small ulcers, oval in shape, with

shelving edges, and coalescing to form a gyrate border. The ulcers are deep, indolent, and covered as to their bases with greyish pus. On the outer side of the same leg, and close to, but not continuous with, the lesion just described, is an infiltrated area resembling that on the right leg as to size and shape, and here too ulceration is commencing. Scattered over the upper part of the left leg and thigh, and chiefly on the outer aspect of the limb, are many small red papules, and a few pustules, one or two of the latter lesions being found on the buttocks.

The child is stated always to have been healthy, though delicate, and there is no history of congenital syphilis. The present condition of things is ascribed to an attack of varicella six months ago, and since that time the patient has never been free from pimples and pustules. The infiltrations have been noticed for the last three months. It seems quite possible that what the mother regards as chicken-pox may have been the pustules of the so-called *Acne scrofulosorum*.

Dr. J. J. PRINGLE brought forward—(1) A case of extremely severe *Pompholyx*, under the charge of his colleague, Dr. Coupland, in the Middlesex Hospital. The patient was a labourer, aged 40, admitted on November 24th, 1894, suffering from chronic Bright's disease of one year's standing, with cedema of the face, albumin and casts in the urine, marked diminution in urea, retinitis, vomiting, headache, dry and pale skin, etc. He had also extensive patches of leuco- and melanoderma on the arms and trunk, of many years' standing. He was ordered a diuretic mixture containing liquor ammoniæ acetatis and a hot-air bath every other evening. It was observed that he sweated only slightly in the baths.

On December 5th it was noted that the skin at the base of the thumbs, across the palms, and extending about one inch on to the dorsum of the hands, was thickened and tender. The tenderness greatly increased, and blebs appeared on December 7th.

When exhibited, both hands and feet were enormously swollen, and covered with tough, tense, circular bullæ, most marked on the palms and soles, where some were as large as a turkey's egg, none of which had ruptured, but the contents of which appeared to be opalescent. An ill-defined eczematoid condition extended up the

arms nearly to the elbows with papules and vesicles, the contents of which had a neutral reaction. Some members thought the patient had local hyperidrosis. The exhibitor raised the point as to whether the condition could be the result of the hot-air baths, but no personal experience could be contributed by any member.

(2) A woman, aged 43, with an anomalous neoplastic and ulcerating condition of the skin of the feet and legs of eight years' duration, the general health being unaffected. The microscopical characters of a nodule excised in 1888 had been regarded as those of a small round-celled *Sarcoma* or granulation tumour. A considerable majority of members present leaned to the view that the case was an unusual form of *Tuberculosis of the skin*, rather than to the exhibitor's, that it was a sarcoma. When the case is fully studied it will be published.

(3) A boy, Fred. P., aged 12 years, suffering from *necrosing Purpura*, most marked on the left leg. The family history was good, and he was in excellent general health, with no suspicion of congenital syphilis or tubercular tendency, and with no history of rheumatism. He came under observation on June 5th, 1894, and said that "brown spots with scabs" had appeared all at once on his left leg two months previously, accompanied by some swelling of both legs, but without any pain. They had never been raised, and never resembled "blisters." Shortly before coming to hospital they had discharged "yellow matter." The original note runs as follows: "There is cedema of both legs and feet, most marked on the left leg, over the lower and middle third of which on its posterior aspect are eleven ulcers. These vary in size from a split pea to a sixpenny piece, and are very deep and "punched out" in appearance, the edge being abrupt, and the base covered with desiccated blood. Surrounding each ulcer is a halo of violaceous hue, but the skin is not swollen, or infiltrated, or inflamed. There are also present five large circular hæmorrhages, which are obviously the first stage in the diseased process, an observation confirmed by the patient and his grown-up brother. On the back of the middle of the right calf is an ulcer of similar character to those on the left, about the size of a threepenny piece."

The cause and nature of the lesions not being patent, the boy was stripped, when it was found that there was much dilatation and tortu-

osity of the superficial epigastric veins and free anastomosis of them with the dilated external mammary veins, the blood in this venous anastomosis coursing from below upwards. The right long saphena vein was also much dilated, and there was considerable varicosity of all the superficial veins of the right leg, but none on the leg most severely ulcerated. The condition, which the exhibitor considered as indicating thrombosis of the iliac veins—or possibly of the inferior cava—dated back seven years, to an attack of scarlet fever, when the case had been one “of interest” in the Fever Hospital.

Under treatment by systematic bandaging the ulcers had cicatrized, leaving deep scars and pigmentation, and some varicose dilatation of the veins of the left thigh had begun to develop.

(4) A well-defined example of Bazin's *Erythème induré des Scrofuloux* in a girl aged 19. The exhibitor had already brought her to the Society on January 8th, 1890, under the title of *Morbus innotatus*, at a time when the disease was acknowledged by the Society—from several examples already shown—as a distinct “entity,” but before Dr. Colcott Fox had established its identity with the condition described by Bazin, and generally recognized, for many years past, in Paris.

The patient had her first attack in November, 1889, at the age of 15, which began as a painful lump on the back of the left calf, thought to be a boil and poulticed. Subsequently several characteristic, infiltrated, livid, erythematous lesions developed in the skin of both legs, especially on their posterior aspect, but recovery slowly occurred without the lesions breaking down or ulcerating. In March, 1890, she was noted as having quite recovered, but the skin over the sites of the erythematous lesions was depressed and thinned, and covered with an abundant recent growth of hair.

Her second attack began in December, 1890, and was much more severe than her first, lasting with repeated relapses up to the end of April, 1891, although under treatment in hospital. Many of the nodules broke down, one of the resulting ulcers having a base as large as a five-shilling piece. The appearances exactly resembled syphilitic gummatous ulceration, but the condition was almost certainly aggravated by iodide of potassium. In the winter of 1891–92 she had no attack, but in November, 1892, she was again affected, and again ulceration occurred, although not so severely as before. She

then showed her first manifestation of "scrofula"—apart from the eruption—in the form of a glandular abscess behind the right ear, which was opened and scraped. (She had no tubercular family history, and was a remarkably healthy-looking, plump, florid girl, but has since become puffy and anæmic.) She again recovered in April, 1893.

She had another less severe attack in the winter of 1893-4, for which she did not attend Hospital, and her present attack began in the end of November, 1894, but she has difficulty in fixing the date of their onset, as the lumps are painless.

Her legs are now studded with livid lumps, one of which has ulcerated. Absolute rest and firm bandaging seem to be the only measures exciting a distinctly beneficial effect on the case.

(5) An ill-defined example of *Dermatitis herpetiformis juvenum (vel puerorum)* in a boy aged 6 years, the difficulty in diagnosing which was due to the abortive and imperfect development of the vesicular elements, or to their being promptly destroyed by scratching on their earliest development, itching being extreme. From the age of two months to three years he was said by his mother to have suffered from "eczema," beginning on the cheek as "watery bubbles," and spreading thence all over his body. It left much pitting and thin white scarring, now very obvious over the trunk, especially in the lower abdominal and lumbar regions.

His present attack began in the beginning of August, 1894, and he has been under observation since September 20th, when it was noted that "the recent lesions consisted of various groups of small papules and badly developed vesicles, altered by scratching, and distributed somewhat indiscriminately over the trunk and limbs. A group the size of a shilling was situated in the fold of the left groin, three were present in each popliteal space (where there was some complication from pus-inoculation), and several over the buttocks, the front of the abdomen and sides of the neck, while there is a circular ill-defined eczematoid patch in front of the left elbow."

He was ordered starch baths every night, followed by a weak β naphthol ointment and four minims of Fowler's Solution internally three times daily. A considerable number of fresh lesions have developed, but their grouping is by no means so herpetiform as previously. Throughout the case there has been complete absence of any urticarial

element. The pitting left by recently involuted lesions is obvious. A sulphur ointment substituted for the naphthol on October 25th has had no marked effect for good.

(6) A case of *Lupus Erythematosus associated with Raynaud's disease*, in a delicate girl, aged 17, who had always suffered severely from chilblains in winter, which had become permanent throughout the past two years. Over the face was an accurately symmetrical "bat's-wing" patch of atrophic skin, with patulous sebaceous ducts, the history of which it was impossible to evoke from the patient beyond the fact that it began last summer. The disease appears to have been of the most superficial type, and is only active now on the lower part of the right cheek, where there is a patch of sharply margined erythema about half an inch in diameter, with still considerable desquamation. The ears were unaffected. The hands were cold, blue, and studded with many livid erythematous patches, while there was gangrene of the tips of both little fingers, and threatening gangrene of several others, causing, apparently, extreme pain. Over the toes there were many patches of purpuric erythema.

Several members expressed the opinion that the patch on the face was of artificial production, a view which the exhibitor could not accept, and which subsequent observation in hospital has failed to confirm.

(See somewhat similar case reported in *Brit. Journ. of Derm.*, November, 1894, p. 839.)

CURRENT LITERATURE.

ON THE PYODERMIAS (PYODERMITES). PROF. LELOIR. (*Journal des Mal. Cut.*, Vol. V., 2nd Ser., 1893.)

THIS is a study of the agents of suppuration. By the term "Pyodermites" Leloir means cutaneous affections of suppurative origin. The author accounts for the frequency of cutaneous suppuration, folliculitis, furunculosis, anthrax, abscess, etc., during convalescence from infective disease by the supposition that the microbes are eliminated by the vessels and glands of the skin. Such suppurative accidents frequently followed the influenza epidemic of 1889 in France.

There are some diseases, like diabetes, which alter, in some chemical or other way, the nature of the cutaneous tissues, converting them from refractory soils into soils fit for microbes. Furuncles and anthrax are common in diabetes, and are apt to be grave. The importance of the part played by the tissues in the act of suppuration is shown by Bujwid's observation, namely, that a quantity of staphylococci, too feeble to produce suppuration, sufficed to provoke it on the addition of a certain quantity of sugar. The excess of glucose favoured the formation of the pyogenic micro-organisms. Certain toxic substances being eliminated by the skin may favour these suppurative accidents. Such substances may be formed in certain chronic affections—dilatation of the stomach, renal disease, rheumatism, various auto-intoxications. Folliculitis and acne may be produced in this way.

Possibly it is the products of these microbes which provoke the suppuration. Grawitz, de Bary, de Charrin, and others have shown that sterilized cultures of pyogenic cocci are still capable of provoking suppuration, where injected into living tissues.

Inoculation from within is even compared with the direct external origin of suppuration. The agents of suppuration—*staphylococcus aureus*, *albus*, *citreus*, and the streptococci exist in abundance on us and around us, even those who live in perfectly sanitary surroundings. A microscopical abrasion is sufficient to admit the microbe. The nails are commonly employed as instruments of inoculation. A common occurrence is the formation of secondary pyodermias from a primary focus.

A primary focus may give rise to secondary lesions different from itself. Thus a furuncle may give rise to the pustules of ecthyma, of impetigo, of folliculitis, and *vice versa*.

Sometimes, instead of the suppuration starting from an elementary lesion, it will start from a suppurating wound or a suppurating affection. Thus folliculitis, boils, ecthymata, impetigo may arise in the neighbourhood of a suppurating wound. Instead of a wound a suppurating gland, an abscess or fistula may be the starting point of various forms of pyoderma. A suppurative coryza may give rise to an impetigo, to a suppurative folliculitis, to a coccogenic sycosis of the

upper lip and of the face. The converse is also true, that suppuration may spread from skin to the mucous membrane of the mouth, or nose, or eye.

We sometimes see mothers and nurses affected with paronychia and ecthyma of the hands in the case of children affected with impetigo and ecthyma. The author mentions a number of such cases in which suppurative lesions have been communicated from one member to another of the same family. In rare cases the pus is conveyed, not directly from person to person, but through an intermediate vehicle, such as clothes, toilet articles, utensils, etc. In this way laundresses may become affected with some form of pyoderma. He cites a remarkable case of a man who consulted him many times for anthrax or furuncles of the neck. He wore the same overcoat every time, the collar of which was much soiled. It appears that this overcoat had been the property of his brother, who had died of anthrax of the neck! The author has known animals to be the source of pyodermias. He has seen an affection resembling his "perifolliculites suppurées conglomerées en placards" arise after the application of leeches. A lady who owned a dog affected with anthrax developed, six or seven days later, furuncles on both hands, with ecthyma of the wrists and paronychia.

The lesion varies according to the depth to which the pyogenic microbe penetrates. Thus, when superficial, we have impetigo, ecthyma, paronychia, certain purulent phlyctenules.

When the agents penetrate more deeply, we have discrete suppurative folliculitis, conglomerate perifolliculitis, sycosiform perifolliculitis, phlegmonous hydrosadenitis, furuncles, carbuncles, phlegmons, lymphangitis, suppurative adenitis.

Leloir divides the pyodermias into the pure and hybrid. The pure are produced primarily and solely by the pyogenic organism. One or several species of organism may take part in producing the suppuration. The staphylococcus pyogenes aureus is the one most commonly met with. Examples of pure pyoderma are furuncle, carbuncle, certain varieties of folliculitis, certain varieties of ecthyma and of impetigo, certain onychias.

The hybrid pyodermias are the diseases which have not been caused primarily by suppurative agents, the pyogenic organism being superadded to a preceding pathogenic condition. They are really dermatoses inoculated with pyogenic organisms. The examples of these hybrids most commonly met with are "Eczemas tournioliques" (Leloir), impetiginous eczema, intertrigo with suppuration, lichens complicated by suppurative affections, scabies, phthiriasis (ecthyma, onychia, impetigo, furuncle, lymphangitis).

The manifestations of cutaneous tuberculosis may be modified by the presence and action of pyogenic organisms. The same is true of syphilides and leprides.

Treatment.—Treatment of the pyodermias may be prophylactic or curative. Prophylactic treatment is to avoid immediate contact with persons affected with pyodermias, to disinfect toilet articles, utensils, clothes, etc., of persons suffering from suppurative affections. Ablutions and baths cannot be recommended too much.

Curative Treatment.—This may serve two ends: 1. To sterilize the pyodermias. 2. To prevent auto-inoculation arising from the fingers, clothes, or bedclothes of the patient.

For pure and superficial pyodermias, such as ecthyma, impetigo, certain paronychias, we may employ ointments containing, according to circumstances, boric acid, salicylic acid, salol, dermatol, more rarely iodoform, and sublimate. These

ointments should be applied continuously, and changed once or twice in the twenty-four hours. The deeper pyodermias, such as furuncle and carbuncle, are treated by Leloir in the following way :—

He applies a plaster consisting of

Hydrargyri vivi	20 grammes.
Terebinthini	20 „
Emp. plumbi	50 „
Resinæ puri	10 „
Acid carbol.	7 „
Ext. belladonnæ	10 „

This plaster is spread on a piece of linen in the form of a pad, the thickness of a silver five-franc piece, covered with a layer of gutta-percha, a little wadding, and fixed by means of a soft bandage. The dressing is changed once or twice in the twenty-four hours. Puncture with thermocautery may facilitate the elimination of pus.

When the eschar is eliminated the cavity is packed with salol or iodoform powder according to the case, and the edges of the crater touched with a brush dipped in tincture of iodine or iodoform-ether, or a syrupy solution of chloride of zinc, and the plaster reapplied. When the carbuncle has become a simple wound it may be dressed with iodoform or salol, or dermatol, or boric acid.

L. R.

ON THE NATURE OF ECZEMA. DR. ERNST SCHWIMMER, Budapest.
(*Wiener Medizinische Wochenschrift*, No. 80-84, 1894.)

"WHAT we know of eczema at the present time has reference to anatomical changes and clinical appearances." The anatomical changes consist in a catarrhal inflammation, the essential pathological processes being those of "hyperæmia and transudation." From a clinical point of view, the disease presents a characteristic eruption, accompanied by itching, and running a definite course, and occurs only in persons with a certain individual disposition. Eczema may thus be defined as "an inflammatory affection of the upper corium and neighbouring malpighian layer, which, with the accompanying exudation, leads to an eruption, together with an irritable condition of the cutaneous nerves and a more or less lasting nutritional disturbance of the affected tissues."

In discussing the etiology of eczema, Dr. Schwimmer groups the possible causes under the heads of (1) local and (2) general, subdividing the latter into (a) constitutional diseases and diseases of internal organs, (b) causes connected with the nervous system, (c) micro-organisms. The local causes afford no explanation of the etiology beyond the fact that local irritation can only produce true eczema in individuals predisposed. That eczema has any real relation with general constitutional conditions or with diseases of internal organs the author doubts. That it is dependent upon the action of micro-organisms he disputes, and considers any such connection altogether unproved. He shows that there is much more evidence, clinical and pathological, for considering nervous influence as the chief factor in the etiology of eczema. He suggests, moreover, that the development of the skin and nervous system from the same embryonic layer tends to point also in this direction. Concerning the etiology of eczema he concludes as follows :—"The

morbid agent of the eczema eruption is unknown to us; it appears to lie in the skin itself, and possibly consists in a developmental defect in the nervous-tissue element."

H. G. ADAMSON.

THE EFFECT OF EARLY ANTI-SYPHILITIC TREATMENT ON THE NERVOUS SYSTEM. ARTHUR DEUTSCH. (*Archiv. fur Dermatologie und Syphilis*, November, 1894.)

DR. DEUTSCH reviews the opinions of various authors for and against the early treatment of syphilis, and gives the results of a research undertaken to determine the effect of such treatment in relation to nervous lesions produced by syphilis. In discussing the statistics of the opponents of early treatment he shows that in those cases in which nervous lesions had developed at a later period the treatment had not been commenced sufficiently early. He denies that the severe nervous symptoms in these cases are the result of anti-syphilitic treatment. He describes the early nervous symptoms which may occur in untreated cases, even before the appearance of secondary eruptions, and which, depending upon a hyperæmic condition of the brain and spinal cord, produced by the syphilitic virus, predispose to later organic lesions. From observations on a large number of cases he shows that, if treatment be begun immediately after contagion, this hyperæmic condition, with resulting nervous symptoms, is prevented, and the tendency to later organic lesions is greatly diminished, while, should the treatment be delayed till the appearance of secondary symptoms, and until after the development of the hyperæmic condition of the brain and cord, later organic nervous lesions are much more likely to occur.

H. G. ADAMSON.

CUTANEOUS VERRUCOSE TUBERCULOSIS FROM ACCIDENTAL INOCULATION, IN THE ATTENDANT ON A PHTHISICAL PERSON.

Excision and igni-puncture. DR. THIBAUDET (DE ST. CLAUDE). (*Journal des Sciences Médicales de Lille*, October 20, 1894.)

THE case published by Dr. Thibaudet is interesting in that it shows distinctly its origin by local inoculation. The patient, a woman, aged 40, had slightly wounded the back of her hand while making the bed for her phthisical son. The wound failed to heal, and little by little developed into a warty and scaly plaque, which, when the patient first came under observation eighteen months later was of the dimensions of a two-franc piece. Tubercle bacilli were found in an excised portion. Treatment by excision of the whole area of disease was selected in preference to igni-puncture or scarification, for the following reasons:—The disease was limited to one spot, and in a situation favourable for union by first intention, even after extensive removal of tissue, and, moreover, a rapid cure was advisable on account of the interference of the lesion with the patient's occupation of dress-maker.

Dr. Thibaudet points out that the verrucose type is that usually observed in "professional inoculations—i.e., in doctors, nurses, veterinary surgeons, butchers &c.—and suggests as a prophylactic that persons thus exposed to local contamination should watch with great care the integrity of the skin, and in case of any abrasion to immediately cover such with an antiseptic collodion or similar protection.

H. G. ADAMSON.

THERAPEUTIC NOTES.

COAL TAR IN SKIN DISEASES.

DR. L. LEISTIKOW (in *La Semaine Medicale*, No. 59, 1894) advocates the use of coal-tar in the treatment of pruritus and other itching affections, and states that he has found it produce more lasting effects than wood-tar, oil of cade, etc. It has proved especially valuable in the treatment of dry eczemas of the scalp, neck, abdomen, genitals and extremities, in prurigo, in trichophytiasis, and in psoriasis of the hairy scalp, knees and elbows. Its use should be restricted to localized skin lesions, lest symptoms of poisoning result; it is of itself liable to give rise to an intense erythema, and hence should not be applied to the face, nor should it be used unless the patient can give up his occupation during treatment.

The following preparation is used, application being made by means of a camel's-hair brush:—

Coal-tar	3iss.
Alcohol (95 per cent.)	3i.
Ether	3ss.

The tar may be easily removed by rubbing with olive oil.

PILOCARPINE IN URTICARIA. (*Med. Record.*)

DR. ABRAMS, of New York, recommends very highly the use of pilocarpine in the treatment of acute and chronic urticaria. If the drug be administered with care, and the dose increased gradually, there is no danger in its use. To adults it should be administered hypodermically in doses of $\frac{1}{4}$ to $\frac{1}{2}$ a grain. Children of one year may be treated with $\frac{1}{16}$ to $\frac{1}{8}$ grain by the mouth every evening. Children three years old take from $\frac{1}{16}$ to $\frac{1}{8}$ of a grain of this drug.

DANGERS OF BETA-NAPHTHOL. (*La Semaine Medicale*, No. 59, 1894.)

DR. BAATZ points out a possible danger attending the use of beta-naphthol as an ointment. Two children, aged eight and six years, were treated for scabies with a salve containing 2 per cent. of this drug. Three weeks later, when the skin affection was cured, albuminuria and œdema of both legs appeared, and one child died. Neither of the children had suffered from symptoms of renal disease before. A *post-mortem* examination was obtained, and the diagnosis confirmed.

THE TREATMENT OF PRURITUS VULVÆ. (*Journal de Medicine de Paris*, No. 25, 1894.)

It is recommended that in pruritus of diabetic origin the diet should be regulated, specific treatment adopted, and very hot water applied locally.

When it depends on a local condition, such as chronic eczema of the genital organs, a gonorrhœal vaginitis, a chronic vaginitis with leucorrhœal discharge or

vaginismus with hysterical symptoms, the following application should be employed locally three times daily after irrigation of the vagina with three or four pints of warm permanganate of potash solution (1 : 1,000).

R. Water	450 parts.
Alcohol (90 per cent.)	50 "
Mercuric chloride	1 "
Indigo carmine	·05 "

When the burning and itching are severe, washing with hot water proves efficacious. Salves and ointments should be avoided, lest by their fermentation they increase the irritation. No stimulating drinks or foods should be allowed.

FRECKLES AND CLOASMA.

In the *Wiener Medizinische Presse*, No. 48, 1894, the treatment of freckles and cloasma is discussed. For freckles the application of the following preparation night and morning is recommended :—

Corrosive sublimate	gr. iv to xv.
Colourless extract, hamamelis	} aa 3iiss.
Glycerine	
Alcohol	

As soon as pronounced irritation of the skin has been produced the remedy should be discontinued until after the symptoms of irritation have disappeared under treatment by zinc ointment, when it should be again resumed. If the above application be found too irritating—

Hydrochlorate of cocaine	gr. xv.
Boric acid	3iv.
Rectified alcohol	3vi. 3ii.

may be applied on compresses with almost as good result.

In Cloasma—Corrosive sublimate	gr. ix.
Ammonium chloride	3i.
Rectified alcohol	3iiss.
Colourless extr. hamamelis	3iii.

has been used locally with marked success.

TREATMENT OF CANCER OF THE FACE. (*Universal Med. Journ.*, August, 1894.)

M. A. DARIER reports a series of cases of this affection treated with marked success by daily application of 1 to 20 methyl-blue. If properly used, he states, it may lead to cure without any associated treatment, but it is more rapid in its action if the affected area be first touched with the galvano-cautery. When the tumour is deeply seated it is his custom to inject the drug hypodermically. He believes it to have a specific action upon the disease. When the new growth has caused destruction of a large area of the skin, grafting during the third week is recommended.



DR. SANGSTER'S CASE OF KERATOLYSIS EXFOLIATIVA.

THE BRITISH JOURNAL OF DERMATOLOGY.

FEBRUARY, 1895.

A CASE OF CONGENITAL EXFOLIATION OF THE SKIN.— (KERATOLYSIS EXFOLIATIVA ?)

BY ALFRED SANGSTER, M.B., F.R.C.P.,

Consulting Physician for Diseases of the Skin to Charing Cross Hospital.

THE patient, G. C., a man (aged 24), first presented himself at the skin department, Charing Cross Hospital, about two years ago. As he was somewhat dull of comprehension it was thought desirable to obtain a few particulars as to history from his father.

The father stated that he and his wife were healthy, they had had ten children, four of whom, besides the patient, were living and healthy. There was no history of syphilis or any skin affection similar to that about to be described. The patient's skin was first noticed to be affected at the third week after birth, the forehead showing signs of desquamation. At the end of the third year the condition had become generalized, and has so persisted until the present time.

The patient, though somewhat weak physically, had had fairly good health, his chief troubles being loss of sleep from itching, especially during warm weather. He also suffered great discomfort from obstinate constipation. The father further stated that although the condition of skin about to be described was always present, the patient was liable to "attacks" (thrice or four times yearly), at which times the condition becomes aggravated, and the exfoliation much more active, so that the scales, like hops,

could be gathered in handfuls every morning from the bed. No bullæ had ever appeared on the skin. The patient sweated on the body during hot weather, but at all times freely on the palms and soles.

On stripping the patient the body appeared fairly nourished, and although not muscular or highly developed, it was by no means stunted or ill-favoured. The skin had everywhere a dusky pigmented appearance, deepening in places to a brownish hue, (the patient was dark-complexioned.) Almost universally the surface was divided into areas presenting the following characters:—

1. Extensive tracts (perhaps involving the greater part of the extensor aspect of the arm, or it might be the buttock, or outsides of thighs) of harsh, cracking-like epidermis, much of it thickened and divided up into small quadrate areas, of heaped-up sebaceous *débris*, corresponding to that condition often seen about old ulcerations on the legs. Where not so thickened the skin felt brittle and paper-like, as if the epidermis were dead, and had lost organic connection with the deeper layers below. On picking up the partly-detached margin of epidermis, the latter could be peeled up in sheets three to four inches square, without pain or much inconvenience to the patient. The surface beneath was then seen greyish-white, smooth, soft, and even, without any appearance of protruding papillæ: to the touch there was a slight stickiness. Within some hours the denuded surface became hyperæmic, and even of a brilliant red colour, and the patient experienced smarting of the part, but nothing of the nature of a crust formed, and the epidermis gradually lost its red appearance, became firm, and settled down into the same condition as that removed. The under surface of the sheet of epidermis peeled off, showed a fine meshwork, corresponding to the natural surface markings of the skin, but no prolongations as seen on the under surface of epidermis removed in ichthyosis. Alternating with the above-described tracts were:—

2. Areas where the spontaneous exfoliation of epidermis was taking place. The surface here presented a broken-up, ragged appearance, made up of (a) tags of partly-detached epidermis; (b) flake-like, papery scales with edges turned up: these flakes had a stuck-on appearance, and varied in shape and size, often somewhat angular, and nearly an inch in longest measurement; (c) intervening recently

denuded skin looking red and inflamed. On pinching up the skin it was not noticed to be thickened.

The face presented a somewhat modified aspect, appearing red and shiny, probably from exposure, and the marking of scales by grease, which the patient was always applying for the sake of comfort.

The palms and soles were the only regions not exfoliating or desquamating. Here the epidermis was thickened, sodden, and bathed in sweat.

The parts most affected were the back, abdomen, buttocks, outsides of thighs, even the scalp and glans penis showing desquamation of smaller scales. The only other lesions seen were crusts on the legs covering ecthymatous sores, and excoriations—these chiefly in the hot weather, and due to scratching consequent on the itching. The hair and nails were not noticeably altered. The viscera appeared normal.

The urine was of normal gravity, and contained neither sugar nor albumen. I have not been able to have the patient under close observation, but from what I have seen at intervals, and from other evidence, the following conclusions seem justifiable :—

I. The condition is a malformation of the skin, and congenital.

II. The process is essentially non-inflammatory, having to do with faulty developmental changes in the upper layers of the epidermis.

The question is of course with ichthyosis. If it be insisted on that the latter is essentially a hyperkeratosis and that papillary hypertrophy is pathognomonic of it, then I think the absence of like change in this case is sufficient to differentiate between them. Perhaps it may be more closely allied to the milder types of ichthyosis (*ichthyosis nacrée*) where papillary hypertrophy is not so marked, but which cases are very liable to secondary inflammatory trouble, especially in exposed situations.

The patient was exhibited at the Dermatological Society of London, and as no member present had seen a parallel case it was thought to be worthy of record.

THE FLAT-TOPPED SEBORRHŒIC PAPULE.

BY H. G. BROOKE,

Manchester.

PROBABLY no disease which affects the skin, except syphilis, can boast of so great a variety of lesions as those which are associated together under the heading "seborrhœa." We all know that the term is a vague and objectionable one, and it can hardly be doubted that it has been applied to dermatoses of the most varied kind, some of which may be really worthy of their designation, whilst others are but secondary infections, as it were parasitic attendants on pathological processes which held the ground before their super-vention. The vagueness of the boundaries of the group is due, of course, to the absence of any definite specific criterion, microscopic or cultural (for the *morococchi* and *Fläschen bacilli* can hardly be said to have yet passed the crucial test), and we are compelled to rely on our experience for our diagnosis. Our knowledge of the syphilides is somewhat in the same condition as regards these criteria, but, lacking the mature clinical experience which we have of these syphilitic lesions which has given us the power, even where history and concomitant symptoms are not present to help us, of recognizing almost at once and with certainty nearly every manifestation of the disease, we are driven back, in the diagnosis of any unusual manifestations of suspected seborrhœic origin, to search for their association with the known and recognized primary lesions, *viz.*, the yellow colouration of certain parts of the body, more especially the middle portion of the face; hyperæmic patches, sometimes taking on a salmon-coloured hue, through the mixture of the red with the yellow, and found chiefly on the face; scaling patches of all sizes and of various colours, yellowish, red, or perfectly pallid like the surrounding skin, most frequently and typically seen on the scalp, as pityriasis capitis. But, however close the association may be we have always

to be on our guard against regarding as a purely seborrhœic manifestation what may be simply an admixture of seborrhœa with an entirely distinct affection, for the proneness of seborrhœic processes to mingle with and even mask the lesions of other diseases, such as lupus erythematosus, psoriasis, and syphilis, is now well known.

Cases, however, of undoubtedly seborrhœic nature come from time to time under observation, in which it is not the more advanced developments or complications which lead to doubt, but rather the unusual character of the elemental lesions themselves. As an example of one of these rarer forms may be taken the case of a man, W. S., æt. 35, who presented himself at the hospital in July of last year. His appearance on entering the room was most striking, the whole head and the hands being of an intense dark red colour. On closer examination it was found that the skin covering the scalp, face, and neck was involved in its entirety. It was deeply infiltrated, so that only the coarser furrows could be seen, but was in no way œdematous. There was slight scaling on the neck, face, and ears, and the scalp was covered with a profuse seborrhœic pityriasis of the ordinary type, but exaggerated. The skin of the scalp was not pale, but participated, though not in quite so marked a degree, in the general redness and thickening. Passing downwards on to the neck the continuity of the diseased surface was seen to be broken up, and the initial lesions of which it was composed were easily discernible. They consisted of small pinhead-sized papules situated at the openings of the pilo-sebaceous follicles. They showed the same deep red colour, but whereas the surface of the agglomerated lesion was slightly scaly, the papules were perfectly smooth and had a flat shining top. They recalled more than anything else the papules of lichen planus, but were smaller, had not the whitish waxy top, and showed no trace of the lilac colour which this produces. At the level to which the shirt collar reached the redness and infiltration ceased almost abruptly, and were replaced by a narrow zone of papules which merged almost at once into the normal skin. The lower part of the neck, both back and front, showed only a few scattered discrete examples of the papules.

On the hand precisely the same condition obtained. The whole of the skin was thickened, coarsely wrinkled and slightly scaly, and was of the same deep red, almost livid, colour. Here again the condition only

extended over the exposed parts, but was, probably on account of the looser nature of the clothing, not sharply defined as on the neck, but broken up at the wrist into papules, which rapidly decreased in numbers, until at the middle of the forearm the skin was almost perfectly clear.

This intensity of development in the exposed parts, and rapid, in the neck almost instantaneous, cessation as soon as the covered area was reached, showed obviously that external irritation had played a large part in so accentuating the action of the disease. The man's occupation, moreover,—he had been a tram-driver—gave aid to this supposition, but, curiously enough, on the extensor surfaces of both elbows, in the site commonly chosen by psoriasis, there were precisely similar patches, sharply outlined, but bounded by an edge of the same papules. Both patches were roughly of an isosceles shape, the apex reaching to the middle of the extensor surface of the forearm, that on the right being longer than the left, and also extending slightly above the elbow on to the back of the upper arm. Here exposure could manifestly have played no part, nor was it possible for any direct irritation to have been the exciting cause—at least the man's occupation involved none. The choice may have been determined in the same way as that of psoriasis, which in most cases quickly settles on this area (and the corresponding one on the knee) after it has once started elsewhere. At any rate the point is interesting to note as adding one more to the many points of resemblance, or contact between, the two affections.

Unna states in his article on "Das Seborrhoische Ekzem" (*Volkmann's Sammlung*, No. 79, 1893), that if any elementary form is to be distinguished as primary and essential to seborrhœic eczema it can only be the scaling spot." My objection to Unna's designation of the whole range of seborrhœic phenomena as eczematous I have stated in this Journal some years ago, and the objection is now apparently generally held; but putting aside the name, there can be, I think, no possible doubt but that these lesions, although they were not scaly, but smooth-topped, did belong to the very protean body of eruptions which he has so laboriously and with such minute care synthesized into one clinical group. There was no sign of "eczema" about them, using the word in its older and more generally accepted sense, they did not tend to form isolated groups, nor to vesicate, and they showed

no sign whatever of œdema, although intensely inflamed. They resembled rather, in their method of agglomeration from discrete lesions into large patches, the behaviour of lichen planus papules, to which, as I have said, they bore a superficial resemblance. Their history, associations and course all pointed to their seborrhœic origin. The scalp was typically seborrhœic, though there were no signs of defluvium, and the lesion had spread from there downwards, distinct signs of the festooned outline being discoverable at its lower boundary on the neck. And there was, furthermore, a well-marked *seborrhœa papulosa*, the ordinary "flannel rash," in the usual positions on the back and front of the chest.

The treatment consisted in the persistent use of a mild sulphur ointment (two-and-a-half per cent.) to which some carbolated camphor was added in order to allay the intense itching which the eruption caused. I instructed the patient to come up again in order to have a piece of skin excised for examination, but on stripping him for this purpose I found him to be fevering sharply, and an examination of the chest revealed advanced phthisis, so that the excision was not made. He did not attend the clinic again until September 20th, by which time the lesions, under the free and persistent use of the ointment, had so far disappeared that nothing remained but some thickening and slight reddening of the head, face and elbows; of the papules there was no trace left. That the disappearance was due to the action of the ointment and not to spontaneous evolution was proved by the great amelioration which it almost immediately produced, arresting the progress of the disease and markedly improving it within a few days.

The small flat-topped papule is probably familiar to many observers as one of the simple seborrhœic lesions, for in a slight degree of development I see it not unfrequently, and have come to regard it as characteristic. I have, however, never met with a special description of it in any of the published accounts of seborrhœa. In the case just recorded it was distinctly the elementary lesion, and appeared to be undoubtedly of seborrhœic origin.

REVIEW.

PROF. ROSENBACH ON THE MOULD SUPPURATIVE DISEASES OF
THE SKIN.*

THIS short monograph commends itself to all who are interested in the question of Tinea. The writer is well known to bacteriologists. He has appeared before the profession as the author of an important work on the "Micro-organisms of Wound-infective Diseases of Man." While busy with the practice of surgery, he has drawn from the hours, usually devoted to rest, time to pursue an arduous research, demanding much technical skill, and to contribute a valuable article on a subject beyond the province of practical surgery. A thesis written under these circumstances fairly merits the praise of diligence, courage and perseverance.

The internal arrangement of the book is simple and straightforward. It consists of an introduction, of a section dealing with methods, of another which treats of observations, and concludes with a summary of results.

At the outset the author states that his intention is to deal only with those varieties of trichophyton which produce deep suppuration. In the Introduction Prof. Rosenbach touches lightly on the history of the question, in so far as it concerns his present subject. We must venture, however, to correct him when he refers the reader for the earliest observations on the plurality of the trichophytic species to the writings of Furthmann and Neebe. Long before these observers had made the simplest cultivation, the twenty-second number of the *Monatshefte* for 1887 contained the suggestive observations of Quinke, and M. Duclaux had broadly hinted in Paris the possibility of a plurality of fungi.

Leaving the historical, the writer passes rapidly in review the

* *Über die tieferen eiternden Schimmelerkrankungen der Haut.* Dr. F. J. Rosenbach, Professor in Göttingen. (Pub. J. F. Bergmann, Weisbaden, 1894.)

memoirs of M. Sabouraud. He is not inclined to embrace the views of the French observer without a good deal of reserve. He acknowledges the merit of his research, but cannot subscribe to many of its too fruitful dogmas. The classification into large-spore and small-spore trichophytons Rosenbach believes unwarranted.

The author follows a methodical plan of research. He separates the fungi originally by laying a diseased hair, or a drop of pus from an affected follicle, or sometimes, a particle of the affected tissue itself, on the surface of peptonized agar. So soon as the vegetations have become aërial he removes a portion from the cleanest spot, and distributes it through a little distilled water in a test tube. If this is not successful he cautiously adds a drop of alcohol, but he considers this procedure open to objection, and to be done only in certain cases. The watery mixture of spores is filtered through a six-ply sterilized muslin filter, the filtrate is transferred drop by drop to a series of tubes containing the nutrient soil. From the peptonized agar the vegetations are resown on sterilized potato on which the characteristic naked-eye features of the fungus is developed.

Dr. Rosenbach's method of isolating the mould fungi seems to us a little too circuitous. The more elaborate the method the more dangerous it is, and the more likely to admit of contamination. The author does not share Sabouraud's objections to the use of Koch's method of mechanical separation, and the experience of many years warrants our confidence in that method, although on some occasions it may fail. We are pleased to note that Dr. Rosenbach is not disposed to make naked-eye observations a basis of classification. He recognizes the variability of these characters, and, unconsciously, endorses a fact which we pointed out some time ago, that temperature is the most important of all factors in inducing variation.

The second part of the book is a record of observations. He portions out into seven groups the deep suppurative tinea which experiments in culture have rendered him acquainted with. Each group he describes clinically and bacteriologically. We are not oppressed with descriptions of minute naked-eye characters. Fortunately for the reader, photography takes, to a large extent, the place of text. The coloured drawings in Plate I. assert an easy superiority over the photographs. The following is an epitome of the seven groups :—

GROUP A.—*TRICHOPHYTON HOLOSERICUM ALBUM*.—Two cases. First, a circumscribed papillomatous suppurating sycosis of chin and upper lip. Second, a ring of herpes tonsurans, about size of palm, on inner side of the thigh, margin bright red and scaly, centre pale. Same fungus cultivated in both cases. Gonidia sessile, serial; septated spindles present, but not numerous. Fungus inoculated on human subject, followed in three weeks by a hard infiltrated circumscribed patch, difficult to cure. Fungus recultivated from the indurated patch.

GROUP B.—*TRICHOPHYTON FUSCUM TARDUM*.—Five cases. First, indurated, suppurating nodules covering cheek and neck, four weeks' duration. Second, a patch of indurated nodules under right angle of jaw, two weeks' duration. Third, rings of herpes circinatus with dark red margins, situated on the neck. Wife suffers similarly. Fourth, a circular patch on left side of neck dotted over with a pustule-like efflorescence; quite superficial induration: sister said to have a similar patch. No contact with animals. Fifth, herpes circinatus on cheek beneath left eye, a broad inflamed zone of dark red colour, granular surface, no vesicles, pustules, or scales; general appearance suggestive of angioma; no contact with domesticated animals; cured by red precipitate ointment. Same fungus cultivated in all five cases. In Case 1, the fungus was cultivated from unbroken pustules. Gonidia long, pedunculated (not sessile), arrangement serial and in grape-like clusters. No spindles observed.

GROUP C.—*TRICHOPHYTON PLANUM FUSOLARGUM*.—Two cases. First, suppurating, indurated nodular patch beneath right angle of lower jaw, fourteen days' duration. Second, herpes circinatus on back of hand. Same fungus cultivated in both; gonidia in masses; gonidiaphores branched, spindles numerous.

GROUP D.—*TRICHOPHYTON PLICANS FUSISPORUM*.—Single case. Deep suppurative sycosis, consisting of confluent indurated nodules on the chin and the neck. Potato cultures characterized by their convoluted surface. Gonidia originally round, becoming elongated. Spindle-like structures present.

GROUP E.—*TRICHOPHYTON FURINACEUM ALBUM POLYSPORUM*.—Single case. Fourteen days' duration, flat tumour of firm consistence situated on the left cheek, scattered over with white and yellow nodules and points; a few drops of pus expressed by pressure. The culture on potato quick growing, forms concentric rings of mealy appearance. Gonidia abundant and arranged like grape-clusters. Spindles largest in this variety.

GROUP F.—*TRICHOPHYTON CANDIDUM ENDOSPORUM*.—Single case. Herpes circinatus on ball of left thumb, scattered vesicles and infiltration of the whole of left forearm. Fungus differed much in growth and spore formation from the other fungi; forms a white silken-like pellicle on potato. Gonidia few in number, with no tendency to cluster. No spindles. Egg-shaped bodies in the mycelial filaments.

GROUP G.—*TRICHOPHYTON PROPELLENS SEPTUM*.—Single case. Peculiar eruption on neck, having form of gyrate map-like figure covered with fine scales. Eruption spread slowly, and of some months' duration. Six cultures developed the same fungus, which grew rapidly on potato; surface of vegetation spongy-looking, and surrounded by a brown ring. Gonidia oval, pedunculated, arranged in clusters. Spindle-like structures present.

This research, as recorded in this monograph, has not been pushed far enough to be complete. It establishes no new doctrine. The

cautious spirit of its author is commendable. There is too much Latin in the christening of these fungi, but the author does not claim for them the dignity of "absolutely distinct species," although he has introduced them to us with very imposing names. Group A has been most investigated, the fungi having been proved by direct inoculation to be pathogenic. The repeated culture of trichophytic fungi from unbroken *pustules* is certainly favourable to the view that pus in the trichophytoses is not always due to contamination by cocci.

But Dr. Rosenbach's cases, grouped as they have been in relation to certain mould fungi, afford no supporting evidence to those who are disposed to admit the doctrine that like fungi produce like lesions. The lesions in Group B present the widest diversity—from deep suppurating nodules to superficial erythematous rings—but nevertheless out of each of these five diverse lesions the author cultivates the "same kind of fungus." The pus-forming quality of certain trichophytions may, possibly, be purely relative, depending on the position of the fungus. On the other hand, the most anaërobic of the trichophytions are the most pathogenic, and the real distinction between Rosenbach's fungi may lie in the capacity for deep vegetation which some exhibit to a larger extent than others. This capacity for deep vegetation is far more likely to be a dividing line than the author's culture tests and gonidia forms. The gonidia, which is the analogue of the bud, is a structure open to many variations of colour, form, and arrangement, and these variations depend on conditions badly defined and dimly understood. In Group B, the question is this:—*Is the surface-growing fungus of Case 5 (superficial erythema) identically the same kind of fungus as that which in Case 1 produced deep suppuration?*

The whole issue of the argument turns on this question, and it is worth our while to take pains to solve it. Those who are not disposed to admit the identity, may reasonably ask what is the worth of culture tests and gonidia or bud-forms which cannot help us to distinguish a fungus which produces a superficial erythema from a fungus which produces a deep destructive and distressing disease? To say with Rosenbach that the variation in the clinical phenomena is a mere matter of position, is to beg the question. He has presumed to infer this on grounds of analogy. At the most crucial point of the whole research he has forsaken the

scientific method of proving all things, and has fallen back to grounds of analogical reasoning. A scientific answer to the question which we have proposed would form an epoch in the history of the tinea question. A wide and extensive research will be necessary for its solution, but Dr. Rosenbach's talent for taking pains may win for him the honour of finding the answer.

LESLIE ROBERTS.

SOCIETY INTELLIGENCE.

DERMATOLOGICAL SOCIETY OF LONDON.

At an Ordinary Meeting of this Society, held on Wednesday, January 9th, 1895,

Dr. RADCLIFFE-CROCKER showed a case of *chronic Pityriasis rubra after Psoriasis* in a man, æt. 60, who had suffered from Psoriasis for over twenty years. During the last ten months the character of the eruption had gradually changed from a patchy to a diffuse form of dermatitis, but it had become universal only during the last six months, and even now on the upper part of the chest there were minute areas of normal skin. The process was essentially that of a chronic dermatitis. There was marked thickening of the skin, so that the natural lines of the skin were much accentuated, producing what Brocq calls lichenification in a high degree on the arms and forearms. The hyperæmia was very moderate, and everywhere the scales were small and branny, and in some parts on the limbs and back were adherent into an encrustation. There was no visceral disease, and the general health and nutrition were well maintained.

Dr. Colcott Fox exhibited (1) a baby, aged seven months, which had been brought to his Skin Department that afternoon. There was a papular eruption, the elements of which were the size of a large pin's head, scattered pretty copiously over both aspects of the limbs. There were far less on the trunk. The face was the seat of slight desquamation all over. Duration of the eruption one week. There were no signs of scratching, though the spots were said to itch. These papules were abruptly raised, pale, more or less polygonal, flat-topped, smooth and polished, with a central punctum; indeed the resemblance to the Lichen planus papules of adults was very striking. On the abdomen were two or three papules, which were rather convex in projection and rounded in outline, but other-

wise the papules seemed to be all of one type. On the calves the papules were aggregated into large patches. The exhibitor said he always taught that in the presence of such papules it was essential to remember that many forms of inflammatory papules became flat-topped in the course of involution, and closely simulated Lichen planus, especially the acute and smaller patterned Lichen planus. This was quite common in the *Urticaria papulosa* of infants, and could be observed in the course of almost every case. He founded his diagnosis of *Lichen planus infantum* in the present case on (1) the close similarity of the papules to those characteristic of Lichen planus, even to the central punctum, present in many cases; (2) the uniform character of the papules, their short duration, and the absence of any intermediate stages to inflammatory papules in course of evolution and involution; (3) the statement of the mother that she had never seen any red or white blotches or wheals. It should be noted that on her way from the hospital a white wheal had developed on the inner side of one knee. The child was free from rickets, and did not sweat at all notably.

(2) Dr. Colcott Fox demonstrated a case of *Tuberculous infection of the arm by the lymphatics*. The woman had suffered from indolent Lupus vulgaris of the forearm for many years, when a hard cord, the size of a small goose-quill, appeared just under the skin of the inner arm from the elbow nearly to the axilla. The glands in the axilla were apparently quite free, but immediately above the elbow on the inner side a gummatous lump appeared and slowly suppurated. This was scraped out, but the scar was not healthy in places. Several operations had been carried out for the lupus of the forearm, which was now nearly well. There was a tuberculous family history on both sides of the woman's family, but she enjoyed fairly good health.

(3) Dr. Colcott Fox also brought forward a man, aged 63, with characteristic chronic patches of *Psoriasis* of the forearms of twenty years' duration. He had been a portmanteau maker, of good habits, and had suffered from an attack of gout forty years previously, but not since. There were no tophi. He never had rheumatic fever. The nails were slightly affected with *Psoriasis*. The bones forming the wrist-joints were greatly enlarged, and there was *osteo-arthritis* of the fingers, with wasting of the interossei muscles, flexion of the

end joints and extension of the middle-finger joints. The toes were very slightly involved. A cousin suffered from Psoriasis.

Dr. Fox also exhibited a drawing of the hands and feet of a woman, who had been affected with rheumatic fever, and at the time the drawing was made, applied for the relief of fusiform enlargement of the middle-finger joints, and rupioid Psoriasis. The nails of the fingers and toes were involved.

These cases were brought forward, in connection with Dr. Mackenzie's case shown at the last meeting, to illustrate some of the arthropathies met with in Psoriasis.

(4) Dr. COLCOTT Fox exhibited an English child with *Favus* of the scalp. He remarked that the features of such a case were doubtless very familiar to those who saw a good deal of the disease. In London, however, except amongst immigrants at the East End, favus was comparatively rare, and cases where there were no obvious "favi," and coming unexpectedly amongst other cases, might readily pass undetected for a time. This child came from the suburbs, and had been much neglected. Of late he had slept with a smaller child, who was unaffected. The whole scalp was uniformly encased in a dirty, grey, dry, thick crust, pierced by the hairs, which had been cut short, but appeared healthy. There were the ova of pediculi on these hairs, and the case was regarded at the first glance as due to pediculosis capitis. There was a faint musty smell, but it was not very pronounced. However, on the right temple, just within the hair and standing out from the main body of crust, were two or three fairly well-marked but unmistakeable "favi." These were found to be composed of the characteristic fungus. The duration was stated to be a few months. The origin could not be traced. He had played on one occasion with a dead mouse.

Mr. MALCOLM MORRIS brought forward as an example of *Folliculitis decalvans*, Albert M., aged 10 years. Since birth there has been a patch of baldness, which occupies the upper and back part of the scalp. The rest of the head became covered by hair in the ordinary way, but the bald patch in question remained so during the first seven years.

During the first eighteen months the bald area was "raised up" above the surface, and was "red and blue" in colour; at the end of

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the time it became normal. Three years ago hair began to appear over the patch which, however, never became properly covered.

At the present time there is an irregularly outlined patch, over the lambdoid suture, about three inches across and longitudinally. The patch is partially covered by hairs, which are shorter, finer, and more wavy than those of the normal part. The skin is white and shiny, and shows the ridges markedly.

The *cheeks* are purplish, and have a mottled appearance. There is a projection from the helix of the *prima* at its lower part, larger than the lobule of the ear.

There is no history of syphilis. The boy was born at full term.

Dr. PERRY sent a man, aged 33, with beautifully developed *vesicating Erythema*, of five days' duration, situated on the backs of the hands and forearms, and in unusual abundance on the neck and face. The man was in very bad general health, having recently been out of work, and subjected to great privation and exposure to cold.

Dr. J. J. PRINGLE showed, *for Diagnosis*, a woman, aged 30, presenting deep brown mottled pigmentation, thickly interspersed with pale circular spots, the condition being most marked over the trunk, but also extending over the thighs and over the neck to the face. The eruption was first noticed fifteen months ago. The patient was an epileptic, who had been attending the "National Hospital for Paralysis and Epilepsy for fifteen years, and taking "fit medicine" regularly three times daily. The exhibitor's opinion, that the pigmentation was due to the administration of *Arsenic*, probably given to "guard" bromides, was fully shared by all present, and was strengthened by the condition of the patient's palms, which were sweating rather freely, and exhibited numerous small warty hyperkeratoses.

THE DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.

At the Meeting of this Society, held on Thursday, January 10th,
(1) Dr. PHINEAS ABRAHAM brought forward a girl, *æt.* 20, poorly developed, hysterical, and subject to "fits," and with marked

evidences of infantile paralysis, who had for many years presented a *persistent frigidity and lividity of the skin* of the right leg from the knee to the ankle—the thigh and foot being normal as regards temperature. This condition remains all the year round, in summer as in winter. Both hip-joints are dislocated, and there is a slight redness and coldness also of the left leg. The knee-jerk of the right limb is much exaggerated, while that of the left is nearly absent. On the right shin there are scars from an old operation for removal of necrosed bone. The girl suffers great pain on pressure on the anterior aspect of the right thigh, and the leg and foot then exhibit clonic movements.

The history given by the girl's mother is that as an infant she was quite healthy, and walked until four years old, when she had "rheumatic fever," since which she had never been well. The operation on the leg was performed when she was eight years old. Dr. Abraham alluded to some of the theories which had been suggested to account for the localized asphyxia, thrombus, pressure on the nerve-trunk, &c., and asked suggestions as to treatment, and how the difference in the knee-jerks could be accounted for.

Mr. ANDERSON stated that he believed the case to be one of nervo-vascular disturbance.

Dr. EDDOWES had seen localized injury followed by symptoms of this nature. He cited the case of a gardener who had œdema after a fracture.

(2) A young woman, æt. 24, with well-marked patches of *Morphæa* on the left shoulder, arm, and forearm. The patch on the shoulder came six months ago, according to her statement, after a blow, and has been spreading since; lately it is shifting its position. It is very painful, especially on the upper borders. The other patches have come since the last one appeared. When the girl came under observation last month, there were irregular erythematous blotches on the cheek, and it is possible that *morphœa* may be developing there.

MR. WILLIAM ANDERSON alluded to a form of *morphœa*, little described, where a large amount of thickening is found locally. He had known such cases diagnosed as *scirrhus* of the skin.

(3.) A man with *extensive Syphilitic eruption* on the face, both arms, both legs, and parts of the trunk. The lesions are typical, with serpiginous borders and healing from the centre with scars. When

first seen a few weeks ago there was much ulceration and surface crusting. The patient declared that he had never a spot on his body until fifteen months ago, when the eruption came on his face and body, together with an ulcerated throat and swollen glands in the neck. He disclaimed any primary symptoms, had been married six years, his wife never having had anything the matter with her skin or any illness, but all his six children died in infancy. Improvement under iodide of potassium was rapidly proceeding. Dr. Abraham was inclined to regard it, from the symptoms of last year and the symmetry of the eruption, as a late secondary, in spite of the man's denials, although the present aspect of the individual lesions was that of a tertiary syphilide.

Dr. MACKAY had showed a similar case, where the patient had six healthy children.

Dr. WILKS stated some cases of syphilis acquired in curious ways. He stated a case where a young lady of respectable family contracted syphilis from a kiss, her lover having a syphilitic ulcer on the lip. The patient herself had merely a slight crack on the lip.

Dr. EDDOWES then read a paper on *Exfoliative Dermatitis*.

During the last few years the large and indefinite group of diseases known as Exfoliative Dermatitis has attracted considerable attention both in this and other countries, at the hands of Unna, Brocq, Savill, and others, and it occurred to me that the following case in an animal was worthy of special attention.

It was published in the September ('94) No. of *The Journal of Comparative Pathology and Therapeutics*.

The case is briefly reported, therefore I will read it in the author's own words.

CURIOUS SKIN ERUPTION IN A STEER.

BY J. WILSON-BARKER, M.R.C.V.S.,

Salisbury.

"The following peculiar case came under my observation during the past summer while assisting Mr. G. Parr, M.R.C.V.S., of Salisbury:—

"The subject, a bull, some fourteen months old, had had one

testicle removed when about six months old ; the other could not then be found, but on the 5th May last I cast the animal, and found the testicle beneath the skin, towards the off flank. I removed it with an *écraseur*, dressed the wound with carbolized oil, and according to subsequent accounts the beast did well for about twelve days ; he was then noticed to be off his feed and somewhat swollen at the seat of the recent operation. On visiting the farm I found the beast feverish, and the wound nearly closed. This was opened at once, and after a considerable quantity of dirty yellow fibrinous material had been removed the wound was dressed with carbolized oil, and kept open with a plug of tow. Some medicine was also administered (chlorodyne chiefly). About a week afterwards I saw the owner, and he then remarked, "That was strong medicine you gave the steer ; it made the skin on his nose peel off," but he added that the steer was now much better. I made some excuse about the skin on the nose peeling off, and heard nothing more about the case for a week, when the owner again appeared, bringing with him a strip of skin some fourteen to sixteen inches long, and from two to six inches wide. He informed me the beast was doing well, with the exception that all the white hair (the steer being red and white) was coming off, while beneath this shed skin blood and matter were found. Through the white hair, all over the body, he informed me, blood appeared to be penetrating.

"Thinking the case rather curious I decided to go and see the steer, so, packing my camera in the trap, I drove out to the farm ; I found the animal presenting a curious picture, which I at once proceeded to capture with my camera.

"One of the most remarkable features of the case was that only the white parts of the skin were affected. Every white patch on the body and legs was involved in the shedding process except a star on the forehead. The skin shed appeared to consist of nothing but the epithelial layer, but with that all the white hairs had come away. Some six weeks after the hair over these parts was shed no new hair had arrived, but I have since learned that it is now (September) beginning to grow again. At first when the hair came off thick bloody scabs remained, but with the aid of cold water these soon came away. If forcibly removed bleeding occurred. Cold water may appear a curious application, but no ointment we applied had such a

good effect as the cold water. There was no evidence of much irritation, and the steer was in a large thatched building, which had been very cool during all the hot weather.

"I am utterly at a loss to comprehend why only the white patches of skin were involved, but some of the readers of this note may offer an explanation.

"The parts marked *a* in the photographs (Plate ix) are areas of skin where the hair was matted with dried blood and exudate; *b*, an area from which all the hair had dropped out."

REMARKS.

The case is probably one of extreme rarity; most certainly of great interest, and one which I thought might with advantage be discussed by this Society. So far, though I have made inquiries of several veterinary surgeons, I have not heard that a similar case among cattle has ever been reported.

I have not had an opportunity of seeing the case, but have learned considerable details by the courtesy of Mr. Parr, of Salisbury, with whom I have had a long correspondence. In his last letter to me he states that when he last saw the animal the parts were all healed over, but in some portions of the skin the epidermis seemed to have been destroyed and its place taken by a film of cicatricial tissue. Where hair had reappeared it was fine and thin, showing that many of the hair-follicles had been destroyed. He has kindly promised to let me know if he discovers the present whereabouts of the animal, which has been lost sight of since it left the neighbourhood of Salisbury.

Mr. Parr has kindly lent me a photograph for your inspection, and regrets that he could not procure any of the exfoliated epidermis.

The first point of interest is that this disease occurs in animals. Those who have heard the case will probably be struck by the great similarity which the symptoms show to those of the epidemic skin disease so fully reported by Savill, and so carefully worked out bacteriologically by Russell. Moreover, the time of year at which it occurred corresponds to the date of the infirmity outbreaks.

With regard to the occurrence of the disease in animals generally,

I quote the following from Savill's monograph on "Epidemic Skin Disease" (p. 84) :—

"Up to the present time, the disease has only twice been conveyed to animals. My little dog spontaneously contracted an undoubted attack of the disease. It was accustomed to make the daily round with me of all the wards, and when the epidemic was in progress, its back became red, in places slightly exuding, and very irritable. It was excessively thirsty, restless at night, and subject to attacks of panting without cause. After a week or so it recovered, and then the hair came out in large quantities."

"The other instance was a rabbit which Dr. Klein inoculated with a pure sub-culture, originally obtained from the unbroken vesicle alluded to (Case M. V.). For two days the animal presented no signs, but on the fifth day, the ears and parts of the body became distinctly scurfy and red. This subsided somewhat on the eleventh day, the animal appearing all along in its usual health. On the twelfth day it died without obvious cause."

Brocq, writing in 1890 ("Traitement des Maladies de la Peau"), states that the disease does not appear to be contagious; but judging from the above and other evidence, there appears now to be no doubt but that it can be conveyed from one individual to another.

With regard to contagion in the case which I have read there is no definite evidence as to whether other beasts did or did not contract the disease from this particular animal; but Mr. Parr could not discover that there had been any signs of infection of the animal's attendant, or of other persons about it, or of any other animals with which it had come in contact.

Had this been a drug eruption, we should have expected that, as the parts of the skin covered by white hair exfoliated, the star on the forehead, which was also white, would have exfoliated.

There seems to be little doubt that this disease had a septic origin, for it followed upon an operation and an unhealed wound. The contents of the wound are described as being fibrinous—a point of considerable importance, as showing that the organisms which presumably were present in the wound were probably not the well-known pyogenic staphylococci; and that the disease was not of the nature of ordinary septicæmic or pyæmic conditions, which used to be somewhat common complications following surgical operations.

I would venture to suggest that the probable explanation of the star not being affected, was that the animal was unable to reach that part with his nose, and infect it. It seems probable that the animal's nose was the first part that commenced to exfoliate. All the white parts which were affected appear to me to be well within reach of the animal's nose, while licking himself; and the nose may therefore have been the chief conveyor of infective material from the original wound to the general surface of the body. On the other hand, it is of course conceivable that the products of the decomposition in the wound were absorbed, and led to dermatitis and exfoliation of the surface, as we see occurs in such cases as true scarlet fever, and in so-called surgical scarlet fever.

An extremely interesting point is that the parts covered by red hair seem to have entirely escaped, while the white-haired parts seem to have been universally affected, with the exception of the star on the forehead. In attempting to explain this remarkable fact, it may be suggested that skins which differ in colour, not from mere optical effects such as we see in oedema and infiltrations, but from deposits of pigment, present really a chemical difference in the composition of the tissues themselves. I should be glad if any member could give us any information as to whether the disease is of frequent occurrence among coloured races.

The chief outbreaks of the disease in this country seem to have taken place during unusually hot weather. That being the case, we should not be surprised to hear that the disease was common amongst races inhabiting the tropics, unless there were some racial or other reason to explain its absence.

Since writing the above I have read with interest an excellent paper on the results of a histological examination of skin from Savill's cases, carried out in Unna's laboratory. It would occupy too much time were I to attempt to deal with either the histology or the bacteriology of the subject. My present desire is to add to the already accumulating knowledge of this interesting disease, not to criticize the excellent work of others.

Dr. BOWLES spoke of skin eruptions occurring in animals of fair skin from the influence of the sun. Thus, in Ireland, he had seen a number of pigs with white hair affected with a kind of exfoliative

dermatitis. The peasants told him that dark-skinned pigs were never so affected. He also referred to the fact that white cattle with fair skins imported into India suffered from skin-blisters and erythema.

Dr. SAVILL stated that the chief point of interest about Dr. Eddowes' paper was the surgical condition present. He referred to the various rashes found after surgical operations, and stated his belief that surgical cases were more prone to suffer from exfoliative dermatitis. Animals certainly contracted this affection, as was evidenced by his dog being affected during a workhouse epidemic.

Mr. SHEILD remarked that the history of blood and "matter" and suppuration pointed strongly to the fact that this case was one of ordinary infective pustular eczema conveyed from the discharges of a septic wound. As to the fair parts of the skin being affected, this was no more extraordinary than the predilection of this disease for fair skins and light hair in human beings. There was no evidence that this beast had been exposed to the sun. Animals when ill were usually confined in a shed.

Dr. EDDOWES in reply stated that he did not believe that this case was one of ordinary impetigo eczema, but was really one of exfoliative dermatitis occurring after an operation.

Dr. DAVID WALSH then read a *Note on Anti-Toxin Rash*.

A transitory rash has been noted in a large number of cases treated by the hypodermic injection of anti-toxin. Thus, an erythematous eruption was met with in twenty-five per cent. of the eighty cases reported by Drs. Washbourn, Goodall, and Card.* It appeared from seven to nineteen days after the first injection, and was attended with some amount of itching. Dr. Moisard, of Paris, in a paper published in the *Medical Press and Circular*, summarizes the results of two hundred and thirty-one cases treated with anti-toxin. He says†: "Cutaneous manifestations, sometimes accompanied by pain in the joints, simulating articular rheumatism, were observed in numerous instances. Among these, fourteen cases of urticaria, nine of scarlatiniform erythema, nine of polymorphic erythema, and one of purpura, were noted."

* *British Medical Journal*, December 28, 1894, p. 1418.

† *Medical Press and Circular*, January 9, 1895, p. 84.

Some years ago a similar rash was familiar after the injection of tuberculin. I myself had the opportunity of using that remedy and of seeing it used by others on a somewhat extensive scale in the Birmingham Workhouse Infirmary. A certain number of fleeting eruptions occurred, and in those which came under my own observation the rash was at first minutely punctate and afterwards diffuse. At the time it occurred to me that the dermatitis might possibly be due to an attempted excretion of the tuberculin by the skin. I venture to suggest that some such explanation might account for the occurrence of the anti-toxin rash.

This theory of excretory irritation, as it may be called, appears to be supported by a number of physiological and pathological data. The skin function is to a great extent analogous with that of the kidney. Indeed, the sweat has somewhere been aptly described as a kind of diluted urine. A little inquiry will show that many substances of a chemical or organic nature, when introduced into the blood, may irritate in turn one or all of the channels of exit from the body, as, for instance, bowel, kidney, or skin. If we take the poison of gout, presumably uric acid, we find that it may attack any excretory outlet, and that it is associated with various kinds of dermatitis, with pharyngitis, with bronchitis, with affections of the alimentary canal, and with nephritis. My suggestion is that these disorders are all of them different expressions of excretory irritation, acute or chronic. Again, the poison of scarlet fever irritates all excretory channels, skin, kidneys, and mucous membranes. Dealing with that disease, Dr. Howship Dickinson has insisted that when skin elimination is hindered by the use of inunctions there is an increased tendency to nephritis. Many drugs that cause skin eruptions are found to irritate other excretory outlets. Iodine and bromine, when introduced into the system, are usually eliminated by the kidneys. Should iodine, however, be thrown off by vicarious channels it gives rise to the group of symptoms known as "iodism," characterized by coryza, gastro-intestinal troubles, and various forms of dermatitis. Moreover, in pustular forms of dermatitis due to bromine and iodine, both minerals have been found in the discharges by Adamkiewicz and Guttmann, as mentioned by Dr. Pye-Smith.*

* "Diseases of Skin," Pye-Smith, p.154.

It should be noted that the anti-toxin treatment is often associated with kidney trouble, so that the drug has evidently an irritant action on one great excreting organ. *Primâ facie*, it does not seem altogether improbable that the rash on the skin may be due to the vicarious irritation of another outlet.

The theory of excretory irritation would explain other clinical facts, such as the fugitive rashes noted in tuberculin treatment, in chronic constipation, in surgical scarlatina, in diphtheria itself, and in some ptomaine poisonings. Only a week ago, in Wylde Green, where a whole village was poisoned by a soup distribution, the first sufferer gave a graphic history of her attack, and mentioned that a slight rash attracted her attention before the onset of vomiting and diarrhoea. The symptoms took some hours to develop, so that there was time for the absorption of ptomaines to take place in the stomach and for their subsequent elimination, or attempted elimination, by the skin.

It may be asserted that these rashes are of nerve origin. If so, one would ask if the accompanying nephritis is also a neurosis. In the case of scarlatina both the dermatitis and the nephritis are presumably due to a common cause. If the skin lesion be regarded as of nervous origin then a similar explanation should also apply to the kidney complication. However, I have never heard that anyone claimed a neuritic origin for either symptom in scarlatina. A similar line of reasoning applies to the skin and kidney inflammations following the injection of anti-toxin. Both rash and nephritis are traceable to a common cause, and if one be a neurosis, so probably is the other. From my point of view, the more likely explanation appears to be that both are caused by direct irritation of excretory epithelium.

As to the anatomical elements of the skin involved, I am inclined to think that it may be at some times glandular and at others papillary. When once started the action is of course complicated by many factors, such as constitutional peculiarity, the invasion of micro-organisms, reflex vascular changes, and so on. As everyone knows, any part of the dermis or epidermis may be attacked or altered by inflammation.

Anatomically, there is a striking resemblance of type between the skin and the kidney. In structure, the Malpighian tufts are very

similar to the sweat-glands, while the renal tubules may be compared with the palisade layer of mucous cells lying on the papillæ. Dr. Waller, speaking of the kidney, says:—"As in all secreting or excreting glands, the essential elements are a thin sheet of blood separated by a membrane from a layer of epithelial cells."* That description would apply almost equally well to the ultimate vascular and epithelial relationship of the skin, both in glands and papillæ.

Pathologically, the different elements of both organs may be attacked in similar ways. The broad resemblance between a choked renal tubule in acute nephritis and some catarrhal affections of the epidermis is worthy of note.

It is hardly necessary to remark that this theory of excretory irritation, even if accepted, would not account for more than a limited number of dermatoses.

To conclude, in anti-toxin we have an organic substance introduced into the system, and giving rise, in some cases, to various forms of transitory dermatitis. With diffidence I suggest that these eruptions may be due to vicarious excretion by the skin of an irritant circulating in the blood.

The President, Dr. PYE-SMITH, F.R.S., then read a *Note on the Erythema produced by Injection of the Anti-Toxin of Diphtheria*.

Among the few cases in which I have had occasion to use the anti-toxin method of treating diphtheria, I have three or four times observed the erythematous eruption which Professor Roux described as sometimes following the injection.

It is not the immediate effect of the puncture, for it appears in distant parts. It takes the form of a roseola with well-defined margins, a bright pink colour, and no papules, vesicles, or pustules. After twenty-four hours it begins to fade, and seldom lasts three days. There is little irritation and little smarting, and desquamation is either absent or extremely slight. Its seat appears to be the limbs rather than the trunk or face.

This eruption is of interest, first, because it is manifestly allied to the occasional erythematous rash of rheumatism, and to the exanthems of measles and scarlatina; and thus additional evidence is afforded that these also are due to the circulation of chemical poisons.

* "Human Physiology," Waller, p. 224.

Secondly, the eruption is still more closely allied to the rose-rashes produced by eating mussels and some other articles of food. The animal poison which produces erythema and urticaria in one of these cases has been described under the title "Mytiline," as a ptomaine, an alkaline product, and probably one of the group of amines. With this again we may connect the eruption of copaiba, and those caused by belladonna, quinine, and many other drugs.

But these secondary toxic and medicinal eruptions agree with erythema, in the restricted sense of the word, in the character and form of the rash, in its short course, and its localization.

If this view be correct, we have now another reason for including erythema and urticaria with some medicinal and toxic eruptions, and some exanthems, in a natural group, and for excluding therefrom all chronic eruptions and all forms of superficial inflammation of the skin, or slight degrees of eczema, which find their natural position with dermatitis produced by local irritants, and not due to internal causes.

Dr. MACKAY believed that many of these rashes were due to overdoses.

Dr. SANSOM referred to the erythematous rash found in diphtheria cases, and asked whether this might not be confounded with anti-toxin rash?

Dr. ABRAHAM referred to the similarity between anti-toxin and tuberculin causing these eruptions.

CURRENT LITERATURE.

BLEPHARITIS TRICOPHYTTICA. Prof. V. MIBELLI. (*Giorn. ital. delle mal. vener. e della pelle*, fasc. III., Sept. 1894.)

RINGWORM of the eyelids is a very rare affection, and only four undoubted cases, including the author's two, have been recorded. His first case was that of a child, aged 6. The upper eyelids were more affected than the lower ones, and there were patches of ringworm on the face as well as on the scalp. The father, another son, and a male servant were also affected with the disease, but in them the eyelids had escaped. The source of contagion turned out to be a cow, kept by the father, who was a peasant. Moreover, the latter presented typical *sycois barbæ trichophytica*.

The mid-third of the upper eyelid was chiefly involved, the cilia were broken off, short, generally concealed by a scale, and there was marked redness and swelling of the circumjacent skin. The inner surface of the lid, beyond redness, showed no change. In fact, at first sight, it looked like a case of eczema of the eyelids. The child kept constantly rubbing the eyes. The treatment was epilation, and application of a weak solution of perchloride of mercury. The scalp became healthy with the use of sulphur 8 per cent. and salicylic acid 2 per cent., ointment, tincture of iodine and daily lotions of perchloride. The child was quite well after two months' treatment.

The second case was that of an infantry officer, *ætat.* 26. The left upper eyelid alone was affected, and there were other patches of ringworm on the face, neck, and in the beard. The cilia were distorted, many broken, and some of the follicles showed suppurating points. There was a good deal of pruritus and tumefaction. Similar treatment was adopted, and in the course of three months the patient was quite cured. The origin of infection could not be traced.

Prof. Mibelli insists upon epilation as being the only treatment likely to be successful. A microscopic examination of the eyelashes in both cases showed the fungus to be within the hair-shaft. These looked like "a sack full of nuts," to which Sabouraud has compared the infected hair-shafts. Now, this form of trichophyton—trichophyton endothrix, with delicate mycelium, according to Sabouraud—is regarded to be human in origin. Mibelli's first case undoubtedly was caught from an animal. Further, the hair of the beard of the father of the child (Case I.) and that taken from Case II. showed the arrangement of the fungus—spores and mycelium—to agree with Sabouraud's type of trichophyton ectothrix, with luxuriating mycelium. Mibelli is therefore inclined to the view that, seeing the source of infection was the same in both patients, it is after all a question of "soil" (site of lesion), whether the fungus is endo- or ecto-thrichous. Consequently the author believes that the question of plurality of varieties of trichophyta is by no means settled.

FRANK H. BARENDT.

TWO CASES OF XERODERMA PIGMENTOSUM. With Three Phototypes.
 Prof. TOMMASO DE AMICIS. (*Giorn. ital. delle mal. vener. e della pelle*,
 fasc. III., Sept. 1894.)

BOTH these occurred in the same family. The patients were aged 6 years and 4 years respectively. There was nothing important in the family history. The first signs appeared in both cases during the first year of life. The disease was typical, and implicated the face, lower third of forearms, and the backs of the hands. The skin was harsh, dry and branny with pigment spots thickly disposed, and slight scattered telangiectases. Two years later there were distinct neoplasms on the face, the pigment spots and telangiectases had become more marked. There were depressed scars; ectropion and eversion of the *alæ nasi* were present. The corneæ showed distinct nebulae. In the elder child there was distinct swelling of the lower epiphyses of the forearms. The microscope revealed the following changes:—The epidermis was sprouting into the subjacent derma, which was greatly injected. There were no epithelial nests, but numerous cells were vacuolated. The derma showed a myxomatous structure, and numerous pigment granules were seen extending into the deeper strata of the epidermis.

Micro-organisms could neither be detected in the tissues nor in the blood, which showed numerous eosinophile cells. Prof. de Amicis discusses at length the terminology of the disease, and suggests the addition of *epitheliomatousum*.

The peculiar points about these two cases are:—

1. The affection developing in infancy and occurring in the same family.
2. The epiphyseal thickening and the presence of molluscum in the face of the elder child.
3. The benign character of the neoplasms, for where these were removed no recurrence occurred.
4. The gradual deterioration of the general health, which could not wholly be referred to the disease.
5. The negative results of bacteriological examination and the presence of numerous eosinophile cells in the blood.

He concludes that Kaposi's disease—i.e., Xeroderma pigmentosum—is not a lesion produced by external irritants (cold or sun's rays) or by any known micro-organism, but that it is a special dystrophy of the skin of unknown pathogenesis.

FRANK H. BARENDT.

**CLINICAL STUDY OF LEPROSY BASED ON EIGHTY CASES
 HITHERTO UNPUBLISHED.** DR. ED. BOINET. (*Jour. d: Mal. Cut.*
 Vol. IV., 1892, 2nd Series, December No.)

I.—ETIOLOGY. 1. *Sex*.—Generalized cutaneous leprosy occurred in twenty-one men and six women. Nerve leprosy (general) in five men and seven women; the mutilating form in fourteen men and six women; the mixed form in fifteen men and four women.

2. *Age*.—The majority of those affected with "tubercular" leprosy did not exceed forty years of age. In the nervous form the average age exceeded this considerably. The majority of mutilating cases occurred between thirty and forty.

3. *Period of Origin*.—Leprosy appeared usually between fifteen and twenty. The tubercular and mixed forms in men are apt to begin after twenty.

4. *Contagiousness*.—Contamination is favoured by (1) prolonged sojourn in leprous places (*paillotte*); (2) by the habit of wet nurses of masticating the rice and then pushing it directly into the infant's mouth; (3) by great promiscuity; (4) by the use of unclean utensils; (5) by the frequency of cutaneous ulcerations in the tropics.

5. *Heredity*.—This should rather be called heredito-contagion. Thus, only twelve out of seventy-nine leprous patients admitted frankly to heredity; out of the seventy-nine patients three admitted that one of their children had leprosy. Sometimes the disease skips a generation. The nerve form is more often hereditary than the nodular, and is less contagious.

II.—CLINICAL REMARKS. (a) *The period of invasion* may be marked by some constitutional disturbance, but of indefinite character. Before the new growths appear certain alterations may take place in the skin, viz. (1) hyperæmic stains varying in tint from livid to brilliant red; (2) pigmentary stains forming map-like figures on the back, thorax, abdomen; (3) disturbances of sensibility. In the old stains anæsthesia may be almost complete; hyperæsthesia, pain on pressure, are more frequently met with in the anæsthetic macular form; (4) glandular and secretory disturbances. The fall of hair and eyebrows occurs in the tubercular form. Lesions of nails are rare, but when they occur take the form of rugosities, thickenings, loss of translucency. The total falling off of the nails is rare, and occurred only once out of the eighty cases.

(b) *Neoplastic Period*.—The nodule or leproma may be hypodermic or dermic. The hypodermic leproma, which is rare, may be *isolated* in nodular form, or *infiltrated, en nappe*. The dermic leproma, the commoner variety, occurs also in the nodular or infiltrated forms. The latter form plaques common on the forearm and backs of the feet and hands, but occur also on the face, forming one of the varieties of the leonine type. Thermic sensibility may remain when the other varieties of sensibility have almost disappeared. At a certain period anæsthesia is the rule; it may be preceded by hyperæsthesia.

Complications of the Lepromata.—*Epidermic lesions* are exceptional, but pityriasisiform, ichthyosisiform desquamations occur, also an exfoliation analogous to pellagra, and an alteration resembling a papulo-squamous syphilide.

Cutaneous Lesions.—Atrophia cutis is not infrequently seen. A pachydermatous condition of the lower extremities was observed in some cases, and associated sometimes with pea-sized hard vegetations. Sometimes the skin is brown or violet colour. The lymphatic glands are frequently indolently enlarged.

Lesions of the Mucous Membranes.—Livid granulations in the mouth were observed in one case. A condition of the tongue resembling sclerogummatous glossitis is sometimes observed. Leprous ulcers are met with in the nose, accompanied sometimes by abundant epistaxis, and ending in destruction of the septum.

Eye lesions existed in eleven male cases and thirteen female; in one-third of the cases both eyes were affected. The alterations were:—tubercular (six cases), atrophic (four cases), mutilating (fourteen cases), mixed (four cases).

III.—PERIOD OF ULCERATION.—In one-third of the cases the leprous ulcers were seated on the external surface of the leg, and in one-fourth of the cases on the back of the foot. The ulcers, which are greyish dull and serpiginous, may sometimes invade nearly the whole circumference of the elephantiasic limb. The margins are rarely ragged, generally hard and callous. In some cases the cicatrices are pearly, delicate, colourless, and surrounded by a strongly pigmented margin.

NERVOUS FORM OF LEPROSY.—This form generally begins by neuralgia.

Period of Eruption.—Erythematous macules may be present (scarlatiniform), hyperchromic (*café au lait*) patches sometimes observed. Achromic patches generally resembling leucodermia, sometimes symmetrical, have been observed. Pemphigus leprosus is rather rare, rapid in its development, superficial, seated generally on the back of the fingers. Pemphigus leaving scars is exceptional.

In the *hyperæsthetic period* neuralgia of ulnar and sciatic nerves is common, the former frequently thickened. The hyperæsthesia is followed by anæsthesia, dulness of perception. Later by muscular atrophy and deformities. The course and progress of anæsthetic leprosy is even more chronic than the pure tuberculous form.

Bacteriological Research.—The leprosy bacillus was found in the blood extracted from leprous tubercles or nodules, also in blood from one of the violaceous stains; blood taken from the tips of the fingers (apparently healthy) in six cases, showed in one case the bacillus disseminé mentioned by Flügge and Ferré.

Histology.—The leprosy bacilli are abundant, sometimes isolated, sometimes united into dense masses, colouring strongly. When highly magnified these bacilli are seen to be composed of dots which stain vividly, contained in a cellular colourless substance. M. Boinet believes in the occurrence of giant cells in the leproma, but they are sometimes absent. They are comparable with the giant cells of inflammation and of tubercle. They appear to be the result of an inflammatory process, but they do not appear to exercise any destructive action on the bacilli of leprosy.

L. R.

A CASE OF CUTANEOUS SARCOMATOSIS PRESENTING THE CLINICAL CHARACTERS OF AN INFECTIVE LYMPHANGITIS. MM. HALLOPEAU ET JEANSELME. (*Jour. Mal. Cut.*, Vol. V., 1898, p. 88.)

DRS. HALLOPEAU and JEANSELME's paper consists of a very full and extensive report of a case of cutaneous sarcomatosis, including the clinical history, the bacteriological and histological investigations of the morbid tissues, with the notes of the autopsy.

1. *Clinical.*—A strong young man has a palmar callosity of some years' duration. It ulcerates without appreciable cause, becomes the starting point of nodules, which are disposed along the lymphatic tracts. The nodules are first entirely *subcutaneous*, the skin normal in colour and appearance, being freely movable over the tumour. But as the nodule enlarges to the size of a large nut, the overlying skin becomes livid, adherent to the undergrowing nodules, and freely ulcerates, when a sanguinary fluid discharges. The features of the sarcoma-ulcer they describe as follows:—At first fistulous, it becomes later an open ulcer, resting on an indurated base, with margins sinuous and torn. The bed of the ulcer is uneven, and carpeted with a dead core or slough, which bleeds at the slightest touch. This bloody oozing is one of the most important and constant characters of these ulcerations. The ulcerated period may extend indefinitely, or terminate in cure more or less durable. The cicatrices are violaceous and depressed. Cicatrization is usually only partial. Cicatrices are often destroyed spontaneously, and are never permanent. At an advanced stage a diffuse infiltration extends over the whole of the affected limb, as in the pigmented sarcomatosis of Kaposi.

Bacteriological.—Several varieties of bacilli were cultivated, but none (except

the pyocyanic) were pathogenic to the guinea-pig. These cultures were those of surface-growing microbes. Inoculations of soil made from juices derived from the interior of the tissue remained sterile. Micro-organisms were not found microscopically in the morbid tissues.

Histological.—Of course the histological characters of this disease vary with the stage in which it is examined. While the nodules are subcutaneous and adherent to the deep surface of the derma, the papillæ are normal in length, the superjacent epidermis is healthy. Tracts of small cells are observed following the distribution of the dermal vessels around which they appeared to be arranged. In the middle part of the derma the disease is more pronounced, the fibrous bundles being separated by strands of cells. These cells are very abundant in the region of sebaceous glands. In the upper part of the derma, where the process is more recent, the cells are small and embryonic, some round, some becoming fusiform; in the deeper parts the cells are larger, polygonal, the nuclei still coloured by picrocarmine, but the protoplasm of the cells scarcely at all. At a later stage the capillaries and vesicles appeared much distended and engorged with blood, and interstitial hæmorrhages are observed.

Autopsy.—Secondary nodules of sarcoma were found in some of the internal organs. Four nodules occurred in one of the kidneys, another in the costal pleura, one was adherent to the lung. These secondary nodules consisted of fusiform or polygonal cells like those in the cutaneous nodules. The vessels were very friable, giving rise to hæmorrhages, or blocked up by sarcomatous buds.

Conclusions.—1. Sarcomatous tumours may remain during several years limited to one member. They spread by the lymphatics, and seem to be arrested for some time by the glands.

2. The nodules become the seat of ulceration, which may persist or be followed by cicatrization, as a rule partial and not durable.

3. They present a close analogy with nodular tubercular lymphangitis in respect of their mode of distribution, their character, and method of evolution. They are distinguished by the incessant hæmorrhage which they produce.

4. Hæmoptysis occurring in the course of the disease is in favour of a diagnosis of secondary sarcoma of the lung, if the expectoration does not contain Koch's bacillus.

5. Histological investigation has shown that the causes of the hæmorrhage are the neoplastic buds which obliterate in great number the capillaries and the veins. These circulatory disturbances are followed by foci of degeneration, in which secondary hæmorrhages are produced.

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MR JONATHAN HUTCHINSON, Junior's CASE OF
MYCOSIS FUNGOIDES.

THE BRITISH JOURNAL OF DERMATOLOGY.

MARCH, 1895.

A CASE OF MYCOSIS FUNGOIDES (?).

BY J. HUTCHINSON, JUNIOR, F.R.C.S.,
Assistant Surgeon to the London Hospital, etc.

It is certainly very difficult to suggest the real nature of the disease of which this case is an example, or even to give a name to it which will not be misleading or seem to imply more than can at present be proved. This, however, is undoubted, that it resembled in many respects the malady of which Mr. Malcolm Morris lately published an example in the *British Medical Journal* (1894), under the title of Mycosis Fungoides, and that more than one case of apparently a similar nature has been exhibited at the Dermatological Society of London lately. The chief features were briefly :—

1. The spontaneous occurrence of attacks of inflammation of the skin, slightly suggesting but probably wholly distinct from, true erysipelas. This dermatitis involved practically the whole body, and each successive attack led to increased thickening of the corium and subcutaneous tissues, so that they became permanently raised in thick, tortuous folds.

2. Loss of the skin appendages : thus the patient was left without hair on scalp, face, or trunk ; and all the nails were shed.

3. Enlargement of all the lymphatic glands which were accessible to examination, with a slight tendency to suppuration, but no leucocythæmia.

4. Frequent febrile temperature and progressive loss of strength, terminating in death from exhaustion.

The patient was a strongly-built man, aged twenty-eight, when the skin first became affected, and he was at the time in prison at Wormwood Scrubs ; this was fifteen months before his admission under my care at the London Hospital.

The family and previous history of the patient were very carefully gone into, but nothing apparently material was brought to light. In no branch of the family could a history of skin ailments be obtained. The patient had been a heavy beer-drinker, but owing to his compulsory detention he had for several months been strictly temperate. There was no evidence of his ever having had venereal disease.

The onset was gradual and took the form of a peeling and itching dermatitis of hands and feet, which gradually spread up the body in spite of treatment, until ultimately the head and face became affected some four or five months before his admission, and then all the hair fell out.

The ears, scalp, and every part of the face became extraordinarily thickened, so that, as seen in the Frontispiece, sinuous folds covered with smooth and unbroken skin were formed, somewhat suggesting enormous cerebral convolutions. His expression became entirely altered, and the "leonine" aspect of some cases of true leprosy was imitated. It was difficult to believe that the patient was under thirty years of age, as his complete baldness, as well as other features, gave him quite a venerable appearance. On the trunk and limbs a solid infiltration prevailed everywhere in the skin, being least marked in the penis and scrotum. The pubic hair disappeared almost as completely as that of the scalp, and the nails of both hands and feet were shed, being replaced by dried epithelium and scab. It may be said that, as a rule, the skin was more evenly thickened elsewhere than on the face. Careful examination was made for anything suggesting growth or "granulomatous" tissue ; but none could be discovered. It is true that from time to time, where the surface became excoriated (for instance, on the hands), some slight granulations formed ; but it must be remembered that the patient could not be induced to refrain from constantly scratching himself ; indeed, one of the most prominent symptoms was the irritation, wholly out of proportion to the desquamation, which was (during his stay in hospital of nine weeks) never very marked. Some of the swollen corium was examined for micro-organisms, but with practically negative results ; I should, how-

ever not like to attach any importance to this, as no inoculation experiments were tried. On the thorax and abdomen the thickening was in places somewhat nodular, but there was no definite "growth," *i.e.*, the nodules were apparently merely spots of skin infiltrated by serum and inflammatory hyperplasia.

The progress of the affection was on the whole steadily from bad to worse, with now and then slight temporary improvement. The arms and legs in particular became more and more swollen, owing to attacks of acute inflammation, which at times suggested cellulose-cutaneous erysipelas, but although the temperature was as a rule raised one or two degrees, and occasionally reached 102°, it never presented the abrupt elevations of the latter disease. Many of the joints, particularly those of the hands and the knees, became flexed from the fact that painful fissures developed in the flexures. No drug seemed to have much effect in checking the cutaneous irritation; opium, chloral, antipyrin, each being tried in him. Perhaps the best result was obtained from giving quinine in considerable doses. Externally oatmeal baths, the continuous application of a lotion containing glycerine and subacetate of lead, carbolic lotion, etc., were persevered with for a considerable time.

And now to consider what lesions of other organs than the skin were present. The most important, although possibly it was only secondary to the dermatitis, was a general enlargement of the lymphatic glands. The cervical, submaxillary, inguinal, axillary and supra-trochlear glands were all markedly swollen, but not very painful or tender. One gland suppurated and discharged in the groin, the pus being thick and somewhat green in colour. The spleen was not perceptibly enlarged, nor were the white blood-corpuscles increased materially (red corpuscles 94 per cent. of their normal amount as measured by the hæmatocytometer), the hæmoglobin equalled 50 per cent. The mucous membranes were not affected so far as could be made out, though his tongue was rather deeply fissured. The urine was quite normal, and varied in quantity from forty to seventy ounces *per diem*. No abnormal physical signs were detected in the heart or lungs, though the patient suffered from a dry cough frequently. The thyroid gland could not plainly be distinguished.

His mental condition appeared to be good, although the constant

irritation and perhaps the use of sedatives combined with the frequent febrile condition, evidently depressed him greatly. He ate ravenously, and there was at no time any diarrhoea. It seemed probable that a fatal issue was not far off, and so it proved to be, for not long after leaving the hospital (owing to insubordination), he died in West Ham Infirmary. We are indebted to the House Surgeon, Mr. Vallence, for the information that no autopsy was permitted.

It has seemed worth while to place on record this single case, although one is really quite in the dark as to its true nature. I have already mentioned that it cannot be regarded as unique, since not only other similar ones have been published as examples of "mycosis fungoides," but other milder cases, where the region affected is perhaps the head and neck or one of the extremities, are not unknown. In such there is the same relapsing inflammation of the skin, leading to a chronic condition of hypertrophy, with enlargement of the lymphatic glands. It is probable that the latter is an important element in the disease, owing to its obstructing the lymph stream. So-called "elephantiasis," as met with now and then in England, with its lymphatic engorgement, recurrent febrile attacks, and increasing infiltration of the skin and subcutaneous tissues, presents a fairly close parallel. But in the case now reported, the chief peculiarity was that the whole surface of the body (with the trifling exception of the external genital organs), was almost uniformly involved. I have omitted to mention that the nerve-trunks accessible to palpation were not enlarged, and that there was no anæsthesia or hyperæsthesia of any part of the skin.

LUPUS ERYTHEMATOSUS AND TUBERCULOSIS.

BY H. G. BROOKE,

Manchester.

THE view that lupus erythematosus is an affection of tubercular origin has received strong support from many competent observers, from Besnier, for example, in France, and from Boeck of Christiania, but so far the idea is simply hypothetical. The lesions are, in a large number of cases, so symmetrical (and tend to become so in all as they progress), and its origin is so evidently erythematous, that the failure to discover bacilli in the lesions themselves is not surprising; indeed, we may say, that it would be more surprising to find them in an affection which has from its outset such a tendency to exact symmetry.

It is quite possible that the disease, like other trophic disturbances (as, for example, scleroderma, and some forms of urticaria with secondary changes), may owe its origin to various causes, that is, there may be various ways of exciting the reflex mechanism which brings about its production, and that one of these causes may be the action of the tubercular virus on the trophic centres of the cord. I am quite unable to support the view that all cases of the disease owe their origin to tuberculosis, for many cases, especially if taken early, can be completely healed by almost trifling local treatment. But there are others which undoubtedly do seem to point to the co-operation, at any rate, of the tubercle poison in their genesis; and as, in our ignorance of its etiology, all evidence, either for or against each hypothesis is of value, I append this brief note of a case in which lupus erythematosus existed in conjunction with abdominal tuberculosis, and which seemed to be distinctly influenced, if not directly conditioned by it.

The patient was a married woman, æt. 33. She had been married for twelve years and had borne five children. In childhood she had had measles and scarlet fever, the latter leaving her for some time in a very weak state; but she had never suffered from any illness

from then until the present time. Her family history was excellent, she being one of a family of seven, who were all (with the exception of one who died in infancy from measles) still alive and healthy. Her parents were also both living and in good health. There is no knowledge of consumption or scrofula in any relatives, and her husband is in perfect health. Three of her children are healthy, one died of some heart affection, and the last, aged four months, from some unknown cause, but it suffered, according to her statement, from "weak bones." It was coincidentally with the commencement of this last pregnancy that the first signs of the erythematous condition appeared on the face in patches, of the exact distribution of which she is uncertain, beyond that they were on the "flush-patch" area.

When she first presented herself at the hospital on October 5, 1893, she looked frail, but by no means weak or cachectic, and was quite cheerful. Her husband was of the upper working class, and the family were in comfortable circumstances. She did not complain of her general health, and only on being asked did she mention a slight feeling of weakness, accompanied with signs of acid dyspepsia. Her sole anxiety was the condition of her skin, which was certainly quite sufficient to distract her attention from any but pronounced internal symptoms.

The lesions were typically those of lupus erythematosus, with the usual erythematous edges, atrophic centres, grey scales, and mortar-like plugs in the pilo-sebaceous ducts. They covered the nose and upper lip, extending on to the cheeks on both sides. Passing upwards over the bridge of the nose they covered the forehead and the entire scalp. The whole of the front half of the head was absolutely denuded of hair, and the hair behind was thin and falling rapidly. There were patches of disease on the upper eyelids, but the eyebrows and eyelashes had not suffered. Both ears were extensively affected, and the nape of the neck. From here the disease spread on to the upper part of the back, slightly on to the shoulders, and downwards over the whole of the chest as far as the nipples and the lower part of the sternum. The chest from the neck to the nipples presented a most extraordinary appearance, being covered, as it were, with a network of contingent circinate lesions, each consisting of an outer erythematous border, surrounding a raised grey edge dotted over with comedo-like plugs, which again enclosed a whitish atrophic centre,

from half an inch to an inch across, the whole being irregularly marked with brown pigmentation. The arrangement bore a distinct resemblance to some cases of extensive *Lichen planus circinatus*, not enough, however, to cause any confusion in diagnosis. The hands and arms below the deltoids were perfectly clear, and there was no sign of disease on the abdomen, back, lower extremities or vulva. The mouth was also free.

The treatment first adopted need not be circumstantially detailed. As the eruption was still active and inflammatory, a soothing paste of kaolin, starch, and vaseline, with Liq. plumbi subacetatis was applied, to which Boracic acid and Liq. picis carbonis were added subsequently. From this application she obtained much relief, more than from ichthyol or thiol, which are often of great service in such cases. Internally, her diet was altered, and soda, bismuth, pepsine and nux vomica were prescribed, and later, when she was becoming depressed, aromatic spirit of ammonia with nux; that is to say, no specific medication was attempted, but the more prominent symptoms were directly treated, whilst waiting for an abatement of the acute stage.

Towards the end of November her general condition was obviously deteriorating, and on the 30th, I found that she had a quick pulse, was feverish, sweating at night and coughing. On examining the lungs no dulness was found, but distinct signs of catarrh with fine râles. Fearing the existence of commencing acute tuberculosis, I procured her admission into the Royal Infirmary, where Dr. Thomas Harris kindly took charge of her. Owing to some domestic arrangements she was unable to enter until December 16th.

On the evening of that day the temperature was 100·6° F., and it continued to rise steadily with occasional slight morning remissions, until January 3rd, 1894, when it reached 104·1°. Up to this time careful examination had failed to reveal any abnormality in the chest or abdomen, and beyond the burning feeling in the affected skin, the patient complained only of rheumatic pains in the head, and later in the limbs, which she attributed to the playing of a draught from a door upon her now almost denuded scalp. A patch of the disease which had appeared on the dorsum of her right ring-finger, just before her entrance into the hospital, was now followed by a symmetrical patch on the finger of the other hand, and fresh spots

appeared on the inner canthi of both eyes. At this time also an eruption began to appear on the arms and abdomen, starting at the lower edge of the original lupus erythematosus areas, and spreading downwards to the wrists and pubes respectively. It was composed of ill-defined papules, scattered over an acute desquamating dermatitis base, the whole being of quite an anomalous character, neither eczematous nor having any apparent connection with the older affection, except that of contiguity. The mouth also became very sore, and was found to be covered with minute excoriations and whitish masses, seemingly due to *oidium albicans*.

On January 2nd a few sibilant rhonchi were detected at the apices of both lungs, but no other physical signs of disease. On January 10th she commenced to have diarrhoea of an essentially "typhoid" character, without, however, the presence of any abnormal signs being detectable in the abdomen. The lung symptoms became more marked, there was dulness on percussion behind, great asthenia, tremors, delirium. January 17th.—General improvement and stoppage of diarrhoea. January 18th.—Sudden collapse and death.

The provisional diagnosis made during life was that of abnormal enteric fever with broncho-pneumonia, but the absence of all physical signs of enteric fever in the abdomen (pain, tenderness, tympanitis, gurgling, enlarged spleen), had made the diagnosis very doubtful, so far as the abdominal symptoms were concerned, in spite of the essentially typhoid character of the stools and the pronounced "typhoid" condition of the patient.

Post-mortem.—The brain and cord were not investigated, but the contents of the chest and abdomen were all examined. All were found normal, except the lungs, kidneys, intestines, and mesenteric glands.

In the lungs there were many foci of broncho-pneumonia, but no signs whatever of tubercle. (No microscopic examination was considered necessary.)

The intestines from just above the ileo-caecal valve to the middle of the jejunum showed a series of typical tubercular ulcerations, with miliary nodules of tubercle in the lymphatics of the serous surface. In four places there were strictures in the gut from contraction of the ulcers; one stricture was firm, and would just allow a full-sized catheter to pass. In the middle of the jejunum, above the ulcera-

tions, were several bright red patches of inflammation, but no actual ulceration was present. Some of the mesenteric glands were also hard and calcifying.

The kidneys were enlarged, with all the signs of soft white swelling. There had been albuminuria during her stay in the hospital, but not when admitted, and the whole condition was evidently acute. There was no sign whatever of tubercle.

All the other viscera and the air-passages were normal.

The special interest of the case, other than that of its unusually rapid growth and extension, lies in the conjunction of a marked lupus erythematosus, with an equally well-marked tuberculosis. Whether there was any casual connection between the two conditions remains, of course, unproved; but there is at least a distinct probability that such a connection existed. The unusually rapid extension of the skin lesion, and its much more extensive spread towards the end of its course certainly tallied with the gradual growth and final acute exacerbation of the intestinal tuberculosis. The fact that the patient did not come of a tuberculous stock, but that when in otherwise good health she had been infected with tubercle poison, and that she gave birth to a rickety child a few months after the lupus erythematosus appeared, certainly tend to support the view that the two conditions had a common origin.

The lung and kidney lesions were obviously merely acute supervening complications, the beginning of which was noted in the later stages of the malady.

It is not unusual for inflammatory skin lesions to disappear during acute pyrexia, generally temporarily, but sometimes permanently. In this case the disappearance was complete from the commencement of the pyrexia (December 31st) onwards. For nearly two weeks before death the erythema, which had been almost livid in its intensity, had passed away entirely, and the skin was left slightly scarred and pigmented, but perfectly pallid. The disappearance may have been due in part to the use of an ichthyol and carbolic lotion, which was ordered at my suggestion, but it was undoubtedly in main part owing to the pyrexial condition. Until the temperature rose to so high a level, the eruption was evidently spreading, and fresh lesions were forming. The dermatitis on the arms and abdomen cleared off in like manner, but even still more rapidly.

CLINICAL NOTES.

THE PRODUCTION OF HYPERTRICHOSIS BY LOCAL APPLICATIONS.

BY JOSEPH FRANK PAYNE, M.D.,

Physician to St. Thomas's Hospital and to the Hospital for Diseases of the Skin, Blackfriars.

I HAVE lately had under my care a little boy, seven years old, with a superficial patch of lupus on the left cheek and another on the outer side of the left leg below the knee. Along with other kinds of local treatment (including scraping), which need not here be mentioned, I have tried the method (used especially by Doutrelepon) of keeping solutions of perchloride of mercury (one to four grains to the ounce) in prolonged contact with the diseased patches. The therapeutic effect was good, but what I have now to speak about is merely a secondary effect which resulted from this treatment in the case of the leg. The growth of hair was stimulated in a remarkable degree, the tibial region from the knee downwards, and to a less extent the outer aspect, becoming covered with a thick growth of hair, which in some parts was from a quarter of an inch to half an inch long. On the corresponding part of the right leg there was merely the scanty lanugo commonly met with in boys of that age, none of the hairs being longer than about one-eighth of an inch. The new hair was in colour like that of the child's head—an ordinary blonde.

Now, the same application was used to the lupus on the face, but the same result did not follow, there being no stimulation of the hair-growth, probably because the hair bulbs of that part were in an earlier stage of development. Possibly, also, the growth on the leg may have been stimulated by the part being kept covered and warm.

There could, I think, be no doubt that the hair-growth was actually produced by the perchloride lotion and not by anything else, because the child has been under observation for some years, and this condi-

tion has only appeared within the last two months, during the treatment mentioned above. It remains to be seen whether the growth will be permanent.

Lassar, in an article on the hair, states that a growth of hair has often been observed by surgeons in parts which have been kept for a long time under antiseptic dressings of sublimate. There are other facts also which show that the perchloride stimulates hair-growth, such as its undoubted effect in some cases of ordinary baldness and of alopecia areata, a result perhaps too hastily set down to its antiseptic properties.

In connection with this subject I would remark that I believe the continued use of applications containing sulphur for the cure of acne has some tendency to produce hypertrichosis of the face. I have been struck with the fact of patients who first came to be treated for acne complaining two or three years later of excessive growth of hair on the face. Of course this applies especially to female patients, and no doubt hypertrichosis occurs in women towards middle life quite independently of such causes as this. Moreover, a great abundance of acne in early life shows an abundance of rudimentary hairs, which would explain a superabundance of hair in the same situations later on. But in these cases it occurred too early to be thus explained, and there is no doubt that sulphur is a decided stimulant to the growth of the hair.

Probably the coincidence here pointed out may have been often noticed, but I am not acquainted with any published observations on the subject.

I will end with a practical caution. It would seem that hypertrichosis of the face in ladies is either commoner than it used to be, or else is more noticed, for we see and hear a good deal about it. Now, it is well known not only that formulæ containing sulphur are largely prescribed by the profession for acne in all its forms, but that secret or proprietary remedies containing the same element are used to an enormous extent by the public for any slight affection of the skin of the face. Furthermore, many popular cosmetics, from the well-known Goulard's lotion, now more than a century old, to the "skin-tonics" of modern times, contain perchloride of mercury. The use of such preparations by ladies is very common in all European countries, and may, perhaps, be an explanation of the

fact, if it be a fact, that there has been lately an increase of hairy growth on the female face, especially among the classes rich enough to buy cosmetics. At all events, some caution in the external use of sulphur or mercurial preparations seems advisable, and physicians should not prescribe them to ladies for acne or similar complaints longer than is actually necessary, while their application should be strictly limited to the parts affected.

**A CASE OF TUBERCULOUS LYMPHANGITIS ASSOCIATED WITH
LUPUS VULGARIS.**

BY E. B. PURDON, M.B. EDIN.,

Surgeon to the Belfast Skin Hospital.

THE following case is, I think, of great interest, owing to its extreme rarity. As the appearance of this patient's foot and leg is similar to that of Mr. Cahill's case, recently reported, I therefore think it worth recording.

M. L., aged 24, unmarried, is one of a family of ten. Her father died sixteen years ago at the age of 47 years, from "paralysis of the brain." Her mother is still living, and has always been in good health; one sister died, aged 20 years, of phthisis, and two others died in infancy. All the other members of the family are quite healthy.

The present condition of the patient is as follows:—The disease involves the left foot, leg, and lower third of the thigh, which are greatly swollen, with thickened, brawny œdematous skin, feeling like leather to the touch. On the dorsum of the toes and foot there are several firm nodular masses; they are quite painless, some of them being of a purplish colour, others resembling normal skin. On either side of the ankle are situated rough warty patches resembling *Lupus verrucosus*, and on the dorsum of the second toe there is a chronic ulcer due to the breaking down of one of these masses. Scattered over the front and back of the leg there are patches, irregularly circular in outline, the margins of which are of a purplish colour (disappearing on pressure), the centres being of a soft white satin-like appearance. The patient states that these patches were formerly the seat of nodular masses, whilst the margins of the patches are in places slightly ulcerated, the ulcers being caused by the breaking

down of these tubercles. The skin between these patches is either normal in colour or of a slight pinkish tinge.

The right leg and foot are only very slightly increased in size, the great toe being stiff and immovable, owing to previous disease of the bone ; and there is a patch of thickened, raised, reddish, and slightly scaly skin on the dorsum of the right foot at the roots of the outer toes.

The face presents the ordinary appearances of *Lupus vulgaris*, the septum nasi being almost entirely destroyed by the disease, and the right eye is affected by phlyctenular conjunctivitis.

The general health of the patient is good, and there is no evidence of disease of the lungs or other viscera.

The patient, who is a very bright and intelligent young woman, gives the following account of her illness :—

When 9 years of age she states that the glands beneath the chin became enlarged and suppurated. Three years later the great toe of the right foot became affected, dead bone coming away, after which the toe healed. During the same year “two red lumps” formed on the dorsum of the left great toe, which “burst and discharged matter,” leaving chronic ulcers behind, which finally healed under the application of “blue-stone.” Shortly after this an abscess formed in the skin over the left knee, which took a long time to heal.

When 16 years of age she had an attack of erysipelas in the left leg, and nodular masses of thickened skin developed on the dorsum of all the toes of the left foot, which commenced to swell, and the swelling slowly extended till it involved the whole of the leg and lower third of the thigh.

These attacks of cutaneous erysipelas have recurred several times a year ; they are accompanied by a rise of temperature, vomiting, etc., and after their subsidence the leg still further increases in size.

In May, 1890, *i.e.*, when 20 years old, a nodule of lupus vulgaris was noticed in the skin of the left cheek, which gradually extended over the nose and attacked the right cheek.

Great improvement has occurred in this patient's condition since she first came under observation at the Skin Hospital in September, 1898.

The treatment adopted has consisted in the application of an india-rubber bandage to the limb, frequently touching the ulcers on the

leg with the acid nitrate of mercury and dressing with a stimulating ointment, and the internal administration of cod liver oil and iodide of potassium in five-grain doses three times a day.

Under this treatment the limb has decreased to one-half its previous size, and the tubercular excrescences have become smaller, less numerous, and softer in consistence. The skin of the leg has also become softer and more natural to the touch.

CRITICAL DIGEST.

THE HISTOLOGICAL PATHOLOGY OF DISEASES OF THE SKIN.*

BY DR. P. G. UNNA.

A VOLUME of more than twelve hundred closely printed pages dealing only with the histo-pathology of the skin, without any but the most incidental references to clinical appearances or treatment will be a revelation to those who consider half a dozen lectures thrown into a course of medicine all the attention necessary to dermatology. The book appears as the eighth volume of Professor Orth's *Text-book of Special Pathological Anatomy*.

In the first place it differs in almost every direction from the ordinary type of text-book.

The author, as he tells us in his preface, weighed the respective plans of adhering to the ordinary system of giving a summary of the views on each question, and of commencing from the beginning and working independently through the whole subject, describing his own observations and deductions. Those who know Unna will be little surprised that the balance went down on the independent side; and the result is not so much a text-book, in the ordinary sense of the word, as a huge collection of monographs on the histo-pathology of every known diseased condition of the skin. This method will no doubt not commend itself to every one. Many of those who have worked at any subject like to see their views quoted, even if only to be abused and shown to be wrong, since it shows them, at least, to be worthy of attention, and one or two well-known workers are singled out for this distinction. In discussing rare conditions Unna gives the full credit of their work to those who have been fortunate enough to have the opportunity of observing such cases. But in the discussion of a subject such as eczema, the views presented are mostly Unna's own. And the plan has much to commend it. Where there are grave

* Berlin, 1894 (August Hirschwald, Unter den Linden 68).

differences in the interpretation of certain phenomena there is reason in stating why one adopts certain views in preference to others ; but where there is no such reason long quotations of the views of others are a mere unnecessary waste of space. At the end of each subject is a bibliography, or perhaps it would be more correct to say a list of the more important contributions to each subject. There is, further, some reason in the plan, in view of the contradictory observations which have been made on many diseases. As the author says in his preface, it is little to be wondered that to most works on dermatology the microscopical part is a mere ornamental decoration, when we are told that diseases, clinically distinct, present the same microscopical appearances, and that two cases of the same disease look different under the microscope. The literature, for instance, on psoriasis is very full ; it has formed the subject of many inaugural dissertations, and far too little attention has been paid to the fact that enormous differences may be due to the stage of the disease, its severity, situation and variety, the origin of the material from the living or the dead, and the medium in which it was hardened.

Much attention is paid to cellular, or rather to protoplasmic as opposed to nuclear pathology, which has so largely dominated dermato-pathology, and we have laid before us a multitude of observations on the changes which take place in the body of the cell. For the study of these a host of new methods are given, most of which have been published by the author in the *Monatshefte*. Nothing is more difficult than to determine the value of new histological methods. What gives brilliant results in the hands of its introducer is often stated to be an absolute failure in the hands of others, and doubts are often, most unjustly, thrown on, even the veracity of, the introducer. In using some of Unna's methods, I have not had the success which he describes, but this experience is by no means confined to Unna's methods, and before condemning any new method as useless, it is well to consider whether the failure may not lie with the operator rather than with the method.

The author utters a well-timed protest against the lavish use of the term "round" or "embryonic" cells. The amount of confusion created by the use of these terms is almost inconceivable, and the less they are used the more rapid is likely to be the advance in our know-

ledge. His various methyl-blue methods are, of course, the ones which have uses to separate the various cells which are "slumped" together under those terms, and I might especially mention as a very beautiful one the methyl-blue-orcein method, which is very frequently referred to in the book.

In describing the different varieties of cells, and especially of their degenerations, the author has found it necessary to coin a number of new terms, some of which it is by no means easy to render into English. Most of them are, however, eminently comprehensible, and lead an English author to envy the elasticity and laxity permitted by the German language. In dealing with micro-organisms, too, a number of new terms are introduced, most of them of considerable value, a value which, however, depends very much on their general acceptance. "Impetigo streptogenes," is a short and handy way of describing an impetigo caused by streptococci, and "pyophoric" organisms are organisms which induce suppuration. The doctrine of chemiotaxis takes a very prominent place throughout the book, and we are introduced to the terms leukotaxis, fibrinotaxis and sebotaxis, words which readily convey their meaning.

All through the book it is frequently pointed out that the ordinary conception of the epidermis is a false one. The term interpapillary processes of the epidermis is protested against, and it is insisted that the epidermis is a plate, or layer of epithelium *folds* of which pass down and, by their passage downwards, create the papillæ. It is not the up-growth of connective tissue which creates the furrows, but the down-growth of epithelium. The importance of the recognition of this fact is evident in analyzing the nature of very many processes.

With a natural pride in his own subject, Unna points out how important for general pathology is the close study of the various processes as observed in the skin, where we have the enormous advantage of observing not only the clinical appearances of each case, but of examining the tissues in their actual condition before any of the post-mortem changes, which so hamper the general pathologist, have set in. He hopes, and no doubt justly, that the increased interest in the study of pathological processes, as they affect the skin, will be of great help in the elucidation of these questions in the internal organs.

NORMAN WALKER.

(To be continued.)

SOCIETY INTELLIGENCE.

DERMATOLOGICAL SOCIETY OF LONDON.

At the ordinary meeting held on February 13th, 1895 :—

Dr. ALDERSMITH exhibited some permanently mounted microscopic specimens of ringworm fungus (850 diams) adopting provisionally the nomenclature of Mons. Sabouraud.

(1) and (2). *Microsporon audouini*, from common tinea tonsurans of the small-spored variety, *showing the mycelium*. The specimens, taken from a typical case with powdery sheaths and the circumpilar collarettes, showed that there is mycelium present on the shaft of the hairs.

He criticized Wickham's reproduction of Sabouraud's statement, reported in the *British Journal of Dermatology* for October, 1894, that "the small size of the spores, the absence of mycelium, and their circumpilar position, are three distinctive characteristics of this form of tinea." This statement is somewhat incorrect, for there is always plenty of mycelium to be detected by careful observation in this variety of tinea. There is a network of mycelium on the bulb; and when the circumpilar sheath is removed, or the hair examined above the sheath, plenty of mycelium is to be detected on and (?) partly in the substance of the hair. It is easy enough to demonstrate this mycelium by soaking the stump for a few hours in liquor potassæ, and the two specimens shown were taken from typical cases of microsporon, with well-marked circumpilar collarettes, and masses of small round spores situated around the shaft of the hair, and lying against one another without any very definite arrangement.

The mycelium, in the small-spored variety, is more *irregularly scattered over the surface* of the eroded hair than in the large-spored form, and more irregular in shape and size, and often *serpentine* in form. Five drawings were shown to illustrate these points.

(3) and (4). *Tricophyton megalosporon endothrix* of the *Resistant form* from a case of large-spored tinea of six years' duration. It

is not so common as the small-spored variety, but is often seen in chronic cases with a few stumps, which are overlooked and certified to be cured.

The mycelium *runs up the hair in bands*, with a distinct network at the bulb. The spores are larger than those in the microscopon variety, and the mycelium-spores, or segments, are of double outline, almost square, and make up the threads or bands with divisions something like the spokes of a ladder. The parasite is *intrapilar*, but the exhibitor once observed the mycelium penetrating and uplifting the outer scales of the hair, and appearing on the outside of the shaft. This is also opposed to the statement in the article already referred to, that "the parasite is *only* found in the interior of the hairs." Again, spores and mycelium are to be seen between the shaft and the inner root-sheath of the hair, and, therefore, *outside* the hair.

(5). *Tricophyton megalosporon endothrix* of the *fragile* variety, which is not so often seen.

The case this specimen was taken from was extensive, and had existed some months. Semi-bare smooth patches were to be seen with long healthy hairs on them; and scattered among them were numerous *black dots*, and very short broken-off stumps, simply so rotten that it was practically impossible to extract a single diseased stump, but all broke off very short, almost on a level with the skin. Some were mere black spots, others were twisted up like a corkscrew.

This minute broken-off portion formed this specimen, which was freshly put up; and it showed the large round spores, and the whole substance of the shaft as one mass of the so-called "fish-roe" spores. The mycelium-spores were also arranged parallel to the axis of the hair, *like strings of beads*. The mycelium was very fragile, and difficult to preserve in any specimen.

(6). *A stump removed by electrolysis*. It showed a complete network of mycelium near the bulb; and though at first the divisions of the mycelium were square, somewhat like the resistant form, yet, higher up in the stump, it had *more of the bead-like arrangement* than of the *ladder-like* form of the resistant variety; or, as stated by Dr. Wickham, "these threads, owing to the round shape of the spores, have the appearance of chaplets, and not of bands."

Drawings were shown of all the varieties, as well as of the *Trichophyton megalosporon ectothrix*.

Mr. WILLIAM ANDERSON brought forward T. W., aged 43, machinist. The patient, a stout but flabby man, presented a dark red diffused rash, somewhat erythematous in aspect, covering the greater part of the trunk and extending to the extremities; the margins were festooned and sharply defined, and the surface was somewhat greasy and scaly.

The condition began eighteen months ago as a *Dermatitis exfoliativa* distributed over nearly the whole of the body, and shedding a profusion of large scales. The constitutional symptoms were of an irritative type, but never serious, and there was no albuminuria. Under treatment with creolin baths and calamine liniment he steadily improved, and at the end of five months was almost cured. He was then discharged, and resumed work, but his symptoms during the last few months have been getting worse, although he is still able to get his living. The chief peculiarity now is the change of type which has taken place in the character of the eruption.

Some members present regarded the case as a generalized *Psoriasis*.

Dr. CAVAFY showed, for *Diagnosis*, a married woman, aged 49. She has always been healthy, and had no ailment except varicose veins. About January, 1894, she noticed a small reddened patch of skin over each knee, which very slowly enlarged. Soon afterwards similar patches showed themselves in the right popliteal space, over front and inner part of the right thigh, right groin, and right iliac region. Two similar patches appeared later on the left thigh.

Present condition.—A moderately stout, healthy-looking woman. There are well-marked varicose veins of both lower extremities. In the situations noted above there are large patches of pale pink erythema, from four to six inches in greatest diameter. They are quite level with the surrounding skin, and terminate by well-defined margins, which are slightly convex. The redness disappears completely on pressure, returning rather slowly; there is neither pigmentation nor scarring, and the surface is quite normal, except that of the patch in the popliteal space, which is slightly rough, with a few brawny scales. There is no itching or other abnormal sensation. No member of the Society could express any positive opinion as to its nature.

Dr. RADCLIFFE CROCKER showed (1), for *Diagnosis*, a woman, aged thirty-six, with a yellowish plaque on the upper part of the left temple, which had been present for about two years. It was nearly circular, an inch and a quarter in its longest diameter, had a sharply defined border, was raised about a sixteenth of an inch above the surface, of a pale yellowish-white tint as a whole, but with some fine vessels coursing from the periphery to the centre. She said it began about two years ago as a white spot, and the growth formed round it, and at the end of the first year was not larger than a threepenny piece. The plaque was firm to the touch, like a piece of thin stiff leather imbedded in the skin, but easily pinched up; there was slight tickling in the growth, but no pain. The skin just below showed some small faint atrophic spots only perceptible in some lights. There was no other abnormality. None of the members present could make any suggestion as to its nature.

Dr. RADCLIFFE CROCKER also brought forward (2) a gentleman, aged forty-three, who had one pea-sized tumour on the line of the lower jaw eighteen years ago. Two years later another appeared an inch off, and a year later, when there were still only two, he consulted Dr. Liveing, who considered them to be soft fibromata, and as they were not displaying any active growth, thought they might be left alone. Since then they have gradually increased in number, but only slightly in size, the oldest being not more than a third of an inch in diameter, while the second tumour has joined with others, and is about three-quarters of an inch in its long diameter; there are, in addition, some eight or ten smaller growths ranging between a hemp-seed and a pea in size, and all limited to an area of about an inch and three-quarters along the lower jaw, and not more than an inch and a quarter in the transverse diameter. The whole patch of tumours can be easily pinched up with the skin, and are somewhat soft to the touch, and some of the other tumours have a slightly brownish-red tinge, while others are only the colour of the normal skin. They still suggest the idea of being fibromata, but they are absolutely limited to the irregular patch just described. They give him no pain, but they are just a little more tender than the normal skin to firm pressure. The patient was a perfectly healthy man, and had no other abnormality except a rather large sebaceous cyst at the neck. The general opinion was that they were either *Fibromata* or *Fibro-sarcomata*.

Dr. Colcott Fox brought forward (1) a case of *Lichen pilaris* (Crocker) in a boy aged seven years. Four brothers and sisters are all well and strong, but the mother considers the patient delicate, though without obvious reason. The boy looked healthy, and there is no point of consequence in the family history bearing on the case. The mother stated that three weeks previously she noticed some roughness over the shoulders, and the next morning found distinct patches of eruption on the trunk. Since then the eruption gradually developed.

Present state.—On the front of the trunk are a few rounded or oval patches, pink in tint, or hardly coloured, or uncoloured, characterized by a projection of all the follicles under such patches, and the protrusion of a little spine from each follicle. These areas feel rough and file-like to the touch. There is a strong tendency to symmetry in the patches. Similar patches, but much redder in colour, are seen on the back of each shoulder-joint, over the back are numerous patches, with an obvious tendency to arrangement in accordance with the fibrous framework of the skin. Many of the patches here are large and indistinct in outline, and only fully observable in certain side-lights. Over the loins and buttocks, and on the outsides of the thighs, the patches are again well marked. At the root of the toes there is a patch on each foot. There is also a patch just below the right elbow-joint. The external aspect of the arms is rough, but not strikingly so. The follicles generally of the trunk and limbs appear to be prominent, but the skin, apart from the eruption described, cannot be said to be very harsh and dry. There is no itching to speak of, and no evidence of scrofulo-tuberculosis.

The exhibitor brought the case as a good example of a somewhat rare child's disease, which had been previously illustrated at the Society's meetings. It was well known in London, but, judging from the text-books, very imperfectly distinguished abroad from other follicular affections. Crocker has identified it with the *Lichen spinulosus* of Devergie, and defines it as "an inflammatory disease of the hair-follicles, in which a spiny epidermic peg occupies the centre of the papule." It has to be distinguished from the following affections:—(1) The common *Keratosis pilaris* of Brocq, to which the terms *Ichthyosis* or *Xeroderma pilaris* have also been applied, the *Ichthyose ansérine des Scrofuleux* of Demoine, the *Folliculitis rubra*

of Wilson, the *Ulerythema ophryogenes* of Taenzer. Possibly the generalized projection of the follicles with the desquamation of minuter scales seen in some wasting states in children, and described as *Pityriasis tabescentium*, belongs to this category. (2) True mild *Ichthyosis* (*Xeroderma*), in which the follicles are specially implicated or very conspicuously involved. (3) Some uncommon forms of folliculitis to which the terms *Lichen simplex* or *pilaris* have been applied, and the exact nature of which is perhaps still involved in doubt. (4) *Lichen scrofulosus* of Kaposi, not to be confounded with the scrofulous lichen of some older French authors.

The terminology is further complicated by the application of the names *Keratosis follicularis* and *Ichthyosis follicularis* to Darier's disease, and *Pityriasis rubra pilaris* or *follicularis* to the affection associated with the names of Besnier and Richaud. Considering the various applications of the term *Lichen pilaris*, perhaps Devergie's name *Lichen spinulosus* or Wilson's *Folliculitis setosa* would be more convenient.

The formation of spines appears to be an integral part, as it is the conspicuous feature, of the malady; but the exhibitor has pointed out that similar spines may be present in the *Keratosis pilaris* of Brocq, and he has observed one case of the *Miliary follicular Syphilide* in which they were present.

Dr. COLCOTT Fox showed (2) a girl of 11 years with an unusual *ringed Eruption on the fingers*. On the flexor aspect of the left ring-finger was a ring of eruption extending from the proximal phalanx to the distal phalanx and half way up the sides of the finger. This oval ring was characterized by a smooth, rounded, projecting border, white in colour, doughy in consistence, quite an eighth of an inch wide, and about one-sixteenth of an inch in height. The enclosed area was normal, or perhaps a little reddened. There were no subjective symptoms, except that the border was slightly tender on pressure. On the little finger of the right hand was a similar ring, but rather smaller and broken up in places into rounded nodules. The affection was cutaneous, and seemed to involve all the layers of the skin. The mother stated that the rings each began in a nodule before Christmas, and gradually extended peripherally. There were no rheumatic nodules, and the only suspicion of the presence of rheumatism was some slight aching in the shoulders after walking.

Otherwise the girl appeared in good health. She had never suffered from rheumatic fever.

The exhibitor said he was at a loss to make a diagnosis. The indolent spread of the rings (they were stationary in the week during which the child had been under observation), the depth to which the skin was involved, and the absence of vesication and desquamation, seemed to put "ringworm" out of court. It occurred to him that it might be an indolent form of inflammation, associated with rheumatism and allied to the eruption described by Crocker as *Erythema elevatum diutinum*.

Dr. COLCOTT Fox exhibited (3) a man, aged 25, a cripple from the remote effects of a widespread paralysis at three years of age, said to have resulted from a fall on the head. On the right leg, which had been much paralyzed, were about twenty rounded, hæmorrhagic congestive macules, about the size of the finger-nails. They were somewhat faded and brownish, and presented a seared look, with distinct atrophy in the centre of many. Indeed, they were not unlike *Lupus erythematosus* discs. Two or three had almost vesicated, and the epidermis separated at the slightest touch. The dorsum of the foot was much swollen. The history given by the patient was that on February 7th, during the very cold weather, he felt his leg come over quite cold, with intense smarting pain, and subsequently he found the lesions as described. Urine pale, free from albumen and sugar. Dr. Fox suggested that, although the man had never presented any of the usual symptoms of *Raynaud's disease*, yet the macules were not improbably of this nature. Some winters ago he had observed a very interesting case, in which a girl's ankles and lower legs presented very similar lesions, leaving delicate scars. These lesions were considered by several authorities to be of the nature of *Raynaud's disease*. Somewhat similar lesions had been recorded as occurring in conjunction with the phenomena more frequently met with in the extremities, and the exhibitor therefore thought it well to bring the case forward for discussion. The peculiar distribution and aspect of the lesions was unlike *Erythema multiforme*.

Dr. COLCOTT Fox showed (4) a servant-girl, aged 22, with a ringed erythematous macular eruption of the forearms, hands, knees and insteps. The eruption began on the backs of the hands at the end of January as little red macules, which spread excentrically and

became ringed with a projected border. On the backs of the hands the lesions remained the size of the little finger-nail, whilst on the forearms some of the macules were an inch in diameter, and confluent. The back of the left forearm was free, and the right elbow was affected. The only constitutional symptoms were some aching pains in the legs just before the evolution of the eruption. The patient never had rheumatic fever, nor was any other cause apparent. The members of the Society had no doubt this was a case of *Erythema multiforme*.

Mr. JONATHAN HUTCHINSON, F.R.S., showed an exceedingly interesting case of *Hydrocystoma* with unilateral sweating, a full report of which will appear in the next number of this Journal.

CURRENT LITERATURE.

PARASITES IN PAGET'S DISEASE OF THE NIPPLE. Prof. G. BANTI, Florence. (*Lo Sperimentale*, March, 1894.)

THE breast, which was removed together with the neighbouring axillary glands, was the seat of Paget's disease of the nipple. Professor Banti examined several pieces, previously hardened in corrosive sublimate (5%), Fleming's solution (osmic acid 1%) 80 cc., chromic acid (10%), 15 glacial acetic acid 10 cc., distilled water 95 cc., and finally in alcohol.

The tumour presented in the main the characters of carcinoma as seen in this region; in several of the "cancer-cells" bodies resembling those described by Soudakewitch, Ruffer, Walker, and others, as parasites (?) of carcinoma, were readily detected. Professor Banti states that after having tried several methods, the best results were obtained by staining the sections with carmine and hæmatoxylin; picric acid or orange may be employed as a third stain without interfering with the effect of the other two. The nuclei stain well with carmine, and the parasites assume a typical violet tint with logwood.

The parasites vary from 2μ to 15μ in size: (i.) some show a violet halo, within which is a small violet structure, provisionally termed a nucleus by Professor Banti; (ii.) others show in their periphery delicate lines, radiating centripetally towards a clear, colourless area, in which the violet-stained structure lies (nucleus of the parasite); (iii.) others, again, show the chromatic substance massed in the centre in which the well-stained nucleus lies. Lastly (iv.), others give evidence of a distinct capsule.

Professor Banti regards these bodies as parasitic intracellular organisms, and affirms that in spite of similar behaviour to various stains, they differ *in toto* from the intracellular "inclusions" which occur in cells of carcinoma. His paper is illustrated by several figures, which show clearly the parasites in various stages of multiplication, within the cells of the neoplasm. The drawings show elongation of the protoplasm, rod-like disposition of the nucleus swollen at either end, dumb-bell shape of the parasite, and finally complete division into two. Some of the epithelial cells show even four parasites. Their reproduction is thus one of gemmation, and resembles that of *saccharomyces*.

Professor Banti thinks that this is not the only method of reproduction. Some of the parasites are enclosed in a capsule which takes the carmine stain; the chromatic substance is massed centrally, showing a copper-violet colour. The nucleus, more deeply stained, shows a very small round body (nucleolus) easily recognized. Within the capsule, in the substance of the parasite, diminutive bodies, resembling capsuled cocci of a deep violet colour and surrounded by a delicate colourless areola, are easily recognized. In some specimens the protoplasm of the epithelial cells shows similar stained bodies, which stand out in

marked contrast to the carmine tint. Professor Banti considers these little coccilike bodies to be produced endogenously within the parasite, and capable of bursting through its capsule into the cell protoplasm, where they acquire chromatic substance and thus develop into typical parasites. He bases this view on the cystic character of some of the parasites, from which these little bodies would appear to have migrated. Such cystic structures are irregular in outline, and either show granular detritus faintly violet, or are colourless.

As regards the relation of Paget's disease to carcinoma, he dissents from the views of Wickham and others, and maintains that the mammary tumours, in his case at least, originated solely from the glandular epithelium, and that the bodies described as psorosperms are ordinary cellular inclusions, and having nothing in common with parasites above described. Even the bodies Professor Banti has described with such detail, are rather viewed in the light of secondary importance; for he especially lays stress upon the fact that these bodies were most numerous in the older parts of the neoplasm. In short, the whole question of parasites in carcinoma is still unsettled, and what evidence there is rather tends to assign a secondary pathological importance to the parasites he has figured. Professor Banti does not admit the doctrine of psorospermiasis as applied to carcinoma.

FRANK H. BARENDT.

A CASE OF SO-CALLED TRUE CHELOID COMBINED WITH SCAR-CHELOID. DR. JOSEPH SCHÜTZ, Frankfurt-am-Main. (*Archiv. für Dermat. u. Syph.*, Bd. XXIX. Hft. 1.)

ALIBERT described this affection first, deriving the name from its resemblance to *χελή* a claw (of a crab). He wrote it with a "K," unfortunately. Addison, who was probably aware of Alibert's derivation, nevertheless termed the disease, now better known as Scleroderma, *true keloid*. Addison derived the name from *κῆλς*, a scar. The result was, owing to the same spelling, that a good deal of confusion arose in the minds of dermatologists, and it was Fagge who first showed how the mistake occurred. Cheloid has been divided into two varieties, true cheloid and false, spurious, or scar-cheloid. The former arises *apparently* without any previous trauma, the latter is an exaggerated form of scar; hence the term.

True or genuine cheloid is a very rare affection. Dr. Schütz has seen three cases, all in women, and in the case he describes he was able to examine the growth microscopically. The patient presented over the upper third of the sternum a pink-red cartilaginous growth, and above and below four small growths—the size of lentils—evidently corresponding to suture punctures. The growth had returned, having been freely removed by her medical attendant, who apparently had not recognized the nature of the affection. The wound had healed by first intention. The scar-cheloid was in the site of vaccination marks on the right upper arm, and had existed from childhood; as this had not in any way interfered with evening toilette, the patient had not drawn the attention of her medical adviser to it. Dr. Schütz remarks on the rare appearance of scar-cheloid before puberty.

Fortunately he was able to secure a piece of the primary growth, and the following are the characteristic features:—

To the naked eye the dense white tendon-like structure, separated by a thin seam of normal tissue from the stratum papillare and the epidermis was easily

recognizable. It was very hard, and on that account presented great difficulties to obtaining a section. Embedding in celloidin proved to be more satisfactory than any other method. The sections were stained with hæmatoxylin and carmine. Under a low power, the cheloid occupied the corium, the fibres coursing parallel to the length of the tumour. There was a distinct layer of healthy corium above the growth and adjacent to the stratum papillare, which was normal in every respect. The epidermis revealed no abnormal change in structure or in thickness.

Under a high power the tumour consisted of collagenous bundles of fibres, so arranged as to leave fusiform spaces. These were most marked in the centre of the growth; towards the periphery the fibres showed distinct evidence of fibrillation, and here numerous round and fusiform cells were present. Nowhere could any trace of elastic element be found. In fact, the structure of the growth resembled closely that of cicatricial tissue. As regards the cell element, plasma-cells, spindle-cells and Ehrlich's mast-cells abounded in the periphery, where growth was active. In the centre there was no evidence of growth, or of any degenerative process. Micro-organisms could not be detected. Dr. Schütz concludes—(i) That the growth begins in the corium; (ii) cheloid is not a fibroma; (iii) that from a *histological* point of view the distinction between true and false cheloid cannot be determined, for the injury required for the evolution of the growth may have been inflicted without destroying the epidermis, as, for instance, in the growth of sarcomata after slight traumatism; (iv) the complete absence of elastic elements in cheloid show it to be no hypertrophy of corium; (v) the absence of cells in the growth differentiate it from any of the granulomata.

Finally, Dr. Schütz defines cheloid to be a hyperplastic development of scar-tissue along the course of the blood-vessels, occurring in certain individuals with or without a history of injury inflicted *in situ*. It is circumscribed in character, of local type, but recurring after removal.

Dr. Schütz treated his case with resorcin ointment of increasing strength for four weeks, with the result of considerably reducing the size of the growth.

FRANK H. BARENDT.

ECZEMA IMPETIGINOSUM. Dr. M. CARRUCCIO. (*Clinica Dermosifil. Della R. Univ. Roma*, June, 1894.)

THE patient was a male, *ætat.* 54, with no history of any previous skin trouble, and presented a scattered eruption of pustules on the scalp, lobules of pinnæ face and lower third of right shin. There was also more or less desquamation scattered in spots over the whole integument. Some of the pustules had dried up and formed crusts. His general health was indifferent. There was a certain amount of œdema of the lower extremities, and the lymphatic glands of the neck and groins were distinctly enlarged. The heart-sounds were muffled. The urine was turbid albuminous, but free from sugar. The deposit revealed an abundance of white corpuscles, and renal epithelium as well as granular and hyaline casts.

Cultivations were made from the contents of pustules that had not burst. *Staphylococci albus et aureus* developed in abundance; the latter formed typical colonies after twenty-four hours' insemination. From the urine, under strict precautions from contamination, cultures of *staphylococcus pyogenes aureus* were also obtained. Dr. Carruccio discusses the source of these organisms, and suggests

that the skin affection was caused by infection from the kidneys, rather than *vice versa*. He does not, however, exclude the more reasonable theory that the micro-organisms might have effected their entrance through the horny layer, and that their presence in the kidneys was a mere coincidence as far as the skin disease was concerned.

FRANK H. BARENDT.

AN EXPERIMENTAL CONTRIBUTION TO THE STUDY OF ERYTHRASMA.

DOTTORI AUGUSTO DUCREY ed ANTONIO REALE. (*Istituto dermo-sifilopatico della R. Università di Napoli*, 1894.) (Read at the Eleventh International Congress in Rome.)

IN 1893, in "A Contribution to the Study of Erythrasma,"* Ducrey and Reale described, as constantly present in great abundance in the scales of the lesions, a parasite, consisting of minute spores and fine mycelial threads, and having all the characteristics of *microsporon minutissimum*. They had with difficulty succeeded in obtaining pure cultures of a fungus which was microscopically indistinguishable from that found in the scales themselves, but were unable to reproduce the disease by inoculation of the human skin.

The authors have continued their researches and have made control experiments with scrapings from skin unaffected by erythrasma. In normal skin, and in skin affected with pityriasis versicolor, minute spores and scanty mycelium were found. The spores and mycelium resembled those seen in scales from erythrasma, but they were present in much less abundance. Further attempts were made, but without result, to reproduce the disease on healthy human skin.

As a result of their work the authors arrive at the following conclusions:—

1. That in scales from erythrasma lesions the constant presence of minute spores and very thin mycelial threads, corresponding to the *microsporon minutissimum* can be shown microscopically; but that in scales from healthy skin or places affected with the ordinary dermatomycoses the presence of a large number of these elements cannot be demonstrated;
2. That, nevertheless, from scales of healthy skin or of pityriasis versicolor, cultures made up of minute spores and fine mycelium can be obtained; and the biological study of this microphyte confirms the opinion that it is the same variety as that obtained in cultures from erythrasma scales;
3. That inoculation experiments on man from cultures of the fungus, obtained either from erythrasma scales or from healthy or pityriasis affected skin, have hitherto given negative results;
4. That it is not possible to reproduce the disease by direct transference of erythrasma scales to the healthy skin of another.

The authors admit these facts, viz., that the fungus can be discovered in normal skin, and that the disease cannot be reproduced by inoculation from pure cultures, and at first suggest that the presence of the fungus may be purely accidental and bear no casual relation to the disease. They point out, however, that the fungus flourishes much less abundantly in healthy skin, that the contagiousness of the disease is small, that even inoculation with the scales them-

For an abstract of this earlier paper see *British Journal of Dermatology*, April, 1894.

selves fails to reproduce the disease on healthy skin, that it generally limits itself to certain areas of the body. Each of these facts tends to show that the fungus requires a special soil, a suitable condition of moisture, and of decomposition of secretions, for its full development, and though present in normal skin yet it does not flourish unless these conditions be present.

H. G. ADAMSON.

ON THE PATHOGENESIS OF PEMPHIGUS BULLÆ. E. KROMAYER.
(*Dermatologische Zeitschrift*, Vol. I., No. I., Berlin, 1894.)

By the consideration of Auspitz's doctrine the author was led to the opinion that the "loosening of the prickle-cell layer" might be due to a digestive action of the fluid poured out from the vessels.

In order to demonstrate the correctness of this view sections of normal skin were placed in respectively (1) fluid from a pemphigus bulla, (2) acid-pepsin, (3) saline solution, (4) distilled water, and the specimens were kept at a temperature of 37° C.

Subsequent examination under the microscope showed no change in Nos. 3 and 4. In the sections in acid-pepsin the cells of the lower layers of the epithelium became destroyed in about half-an-hour, and a cavity was thus formed. In the sections in pemphigus fluid no change was observed until about an hour and a half. Then it was noticed that the weight of the cover-glass was sufficient to separate the epithelium from the corium. There was, however, no destruction of epithelium, as in specimens in acid-pepsin, so that Kromayer concludes, therefore, that the pemphigus fluid acts *not by a process of digestion, but simply as a macerating agent.*

H. G. ADAMSON.

NOTE ON "BISKRA BUTTON." AUCHÉ and LE DANTEC. (*Archives Cliniques de Bordeaux*, October, 1894.)

MM. AUCHÉ and LE DANTEC give the results of a bacteriological inquiry in a case of Biskra Button. They describe two forms of micro-organisms, a streptococcus and a staphylococcus—the latter found only sparsely in an unopened abscess, but more abundantly in an ulcerating lesion. The disease was reproduced in a rabbit, inoculated from cultures of the streptococcus, but no results were obtained with the staphylococcus. The streptococcus formed numerous small colonies and grew best upon agar-agar. No organisms were discovered in the blood.

The authors point out that their observations do not correspond with those of previous observers. Duclaux, Chantemesse, Poncet, Heydenreich, have even described a form of staphylococcus resembling the staphylococcus flavus, and with it were able to reproduce the disease in the rabbit and even in man.

Poncet, in addition, observed a bacillus, but was unable to obtain a culture. Heydenreich recognized also in the blood and urine a non-virulent staphylococcus resembling the staphylococcus albus and the innocuous staphylococcus of Auché and Le Dantec. They note that the streptococcus found by themselves can be clearly seen in the plates published with the paper of Poncet.

H. G. ADAMSON.

THE PROTOZOA-LIKE BODIES OF HERPES ZOSTER: A CONTRIBUTION TO THE STUDY OF PSOROSPERMOSIS. Dr. HARTZELL.
(*Journal of Cut. and Gen.-Urin. Dis.*, September, 1894.)

Dr. HARTZELL draws attention to the protozoa-like bodies first pointed out by Weigert in the pustules of variola as "coagulation necrosis," and afterwards accurately described by Pfeiffer. These structures are not present in the ordinary inflammations of the skin, but are peculiar to variola, vaccinia, varicella, and zoster. In the latter disease they are peculiarly numerous and remarkable. Pfeiffer believes these bodies to be parasites of the order of protozoa, which, having gained access to the skin through the medium of the intercostal blood-vessels, produce the eruption characteristic to the disease. Wasielewski shares this belief. These bodies are scanty in the earlier stages of the eruption, increase rapidly later on, and disappear with the appearance of pus. Hartzell studied these bodies in two cases of idiopathic dorso-pectoral zoster of the ordinary type, and also in a case of sciatic zoster which had recurred for ten or fifteen years and had followed attacks of neuralgia, which again had directly succeeded a fracture of the femur. Hartzell considers them not to be protozoa but altered epithelial cells. No useful purpose would be served by a recital of the appearances observed, which should be studied in the original paper with the plates.

T. C. F.

ICHTHYOSIS CONGENITA (SO-CALLED HARLEQUIN FŒTUS). HISTORY OF A CASE STILL LIVING. Dr. SHERWELL. (*Journal of Cut. and Gen.-Urin. Dis.*, September, 1894.)

Dr. SHERWELL makes an interesting contribution to our knowledge of Ichthyosis in his recital of a case of a child born at term in a condition which comes fairly under the denomination of Harlequin Fœtus. The child was still living at about six months old.

T. C. F.

KERATOSIS FOLLICULARIS CONTAGIOSA OF BROOKE: ACNE CORNÉE OF THE FRENCH. (*Journal of Cut. and Gen.-Urin. Dis.*, August, 1894.)

With this diagnosis Dr. Elliot exhibited to the New York Dermatological Society a male patient, aged 14 years, a native of Russia, who presented an eruption of about four and a half years' duration. It began on the upper portion of the back, and gradually spread, partially covering the face, trunk, and extremities. The lesions, for the most part discrete, were in some places aggregated to form large areas. They were pin-head in size, but also larger, slightly elevated papules, of a pale, or darker red colour, containing in their centres a dark, hard, adherent plug, which, when forcibly removed, left a depressed pit, surrounded by a minute circular wall of infiltration. On the backs of the hands were large, pea-sized, fleshy papules, dark red in colour, bearing upon their central portions brown or greenish crusts, which were firmly adherent and occupied more or less shallow pits, the bases of which were apparently slightly warty. There were no pronounced spines or horny prolongations.

T. C. F.

THERAPEUTIC NOTES.

THE TREATMENT OF SYPHILITIC MUCOUS PATCHES. (*The St. Louis Med. and Surg. Journal*, September, 1894.)

PROFESSOR A. H. OHMANN-DUMESNIL, after pointing out that the mucous patch is among the most virulent syphilides, and a very frequent cause of the transmission of syphilis, urges prompt treatment, with a view to the rapid healing of the lesions and the removal of their infective properties.

Prophylactic treatment is of importance, and all causes of local irritation—acid food, pepper, vinegar, spices, etc.—and tobacco, whether in the form of smoking or chewing, should be avoided.

Constitutional treatment should be pushed to that point which insures a rapid and thorough action of the remedy which is administered. The greatest caution should be exercised in the use of mercury, lest the gums become affected and the patient suffer from mercurial stomatitis, for this inflammatory condition favours an extension of the mucous patches and their destructive action.

The local agent which has seemed to him to give the best results is C. P. nitric acid, which is applied by means of a piece of soft wood fashioned after the shape of a small paddle. The application is not particularly painful nor destructive in its action; it does not mask the lesions; can be used in all degrees of ulceration and with rapid results. If the patient be told to expire during the application he is not incommoded by the fumes of the acid. If extensive areas of mucous membrane be involved, a spray of perchloride of mercury (1:500) should be substituted.

FOR FAVUS. (*The St. Louis Med. and Surg. Journ.*, August, 1894.)

THE hair should be cut close, and the following application made until the crusts become detached:—

R	Thymol	3ss.
	Chloroformi	3v.
	Olei oleosi	3iii.

The affected parts should then be carefully epilated, and a solution of

R	Tinct. iodi	2 parts,
	Glycerini	1 part,

painted once a day over the patch.

The following ointment is also recommended:—

R	Losophan	3i.
	Ung. Aquæ rosæ	3ii.
	Lanolin	3vi.

m Sig.—Apply twice daily.

APPLICATION FOR BURNS.

OSTHOFF (*Deutsche medicin. Wochenschr.*, 1898, No. 88, p. 981) recommends the application of bismuth subnitrate made up with hot water into a mass having the consistency of plaster of Paris, and applied to the affected surface by means of a brush. In uncomplicated cases no other dressing will be required.

THE BRITISH JOURNAL OF DERMATOLOGY.

APRIL, 1895.

A CASE OF DESTRUCTIVE FOLLICULITIS OF THE SCALP IN A PATIENT AFFECTED WITH HEREDITARY SYPHILIS.

BY J. F. PAYNE, M.D., F.R.C.P.,

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of the Skin.*

THE following case is one of a somewhat rare disease, which was first described by Quinquaud as Folliculitis decalvans or epilatoria, but here also complicated with more diffuse inflammation. In this case the history unmistakably proved, as will be seen, that inherited syphilis was the exciting cause; but whether this is also true of other cases of the disease I do not undertake to say. Quinquaud exhibited a case of this disease to the weekly meeting of the physicians of the St. Louis Hospital on December 13th, 1888; and on that occasion I find that Fournier stated he had seen a similar case in a young girl, which was due to hereditary syphilis.*

Before this, apparently, Quinquaud had communicated a paper to the "Bulletin de la Société Médicale des Hôpitaux" in 1888.† He had also placed a coloured model of the affection in the museum of the Hospital of St. Louis in 1887 (*Catalogue des Moulages*, No. 1293). The affection has since then been frequently discussed, especially in the French journals. It is mentioned in Dr. Radcliffe-Crocker's and Mr. Malcolm Morris's works on diseases of the skin.

* *Monatshefte für prakt. Dermatologie*, IX. 474, 1889; from *Annales de Dermatologie*, 1889.

† The original is not accessible to me, but an abstract is contained in the *British Journal of Dermatology*, Vol. I. p. 80.

Before it had received a distinctive name, however, I think most dermatologists must have recognized destructive folliculitis of the head, and probably regarded it as a sort of sycosis of the scalp. In fact, the analogy with sycosis of the beard is almost perfect. It is a suppuration of the whole hair-follicle, including, doubtless, the sebaceous gland. The distinctive feature is the destruction of the follicle and permanent atrophy of the skin which results. But this also is not unknown in ordinary sycosis, in which distinct bald and atrophic areas are sometimes produced. I have seen the same result in *Tinea sycosis* or *Tinea barbæ*, when the fungus could be clearly demonstrated. M. Quinquaud attributes the disease to a special form of bacterium which he isolated, and by inoculation of which into animals, destruction of the hairs was produced. This may have been the true explanation of his cases; but, considering the present case and the one alluded to by Fournier, it is possible that more than one cause may give rise to the same destructive process.

The bald patches resulting from this affection have been compared to *Alopecia areata*, and it is thought that it has previously been confounded with the latter disease. In my case, however, the condition of the skin was more definitely atrophic. One observation subsequently noted was that in several instances two or three hairs were seen growing from one hair-sac. This has often been observed in sycosis of the beard, and it was even suggested by Hebra that the growth of two hairs in a confined space might be the cause of the inflammation.* But with our present knowledge of the causes of suppuration this cannot be admitted; and, moreover, the condition is not sufficiently universal. It seems more probable that the inflammation in its earlier stages so stimulates the growth of a secondary hair which is present alongside of the primary one that it projects with the former till both are loosened by suppuration.

I will only observe, by way of precaution, that this condition is entirely different from the *Dermatitis papillaris capillitii* or *Acne keloid*.

HISTORY OF THE CASE.

Sophie M., aged 14, was admitted to the Hospital for Diseases of the Skin as an out-patient, January 20th, 1892. She was small for

* Hebra, *Hautkrankheiten*, 1860, Vol. I. p. 529. He refers to Langer's researches on the mode of growth of secondary hairs.

her age, pale, and very cachectic, with fair complexion and blue eyes. She complained of a disease of the scalp, which had lasted six or seven years; and for which she had been treated for some time at the skin department of a general hospital. It consisted of a suppurative affection of the hair-bulbs, with some diffuse inflammation producing crusts and scales, like a chronic impetigo. A large number of the hair-bulbs were absolutely destroyed, producing a large oval area of baldness some inches long, with glossy atrophic skin all over the vertex, and evidently spreading to the rest of the scalp. The hairs on the sides and back of the head and close to the forehead were comparatively unaffected, but many showed suppuration of the follicles. There were no broken hairs, so that Tinea or Favus could be definitely excluded, but in several instances two or even three hairs were growing from one follicle. The diffuse inflammation was also apparently of a destructive character, and assisted in producing the atrophic bald patches, but there was no true ulceration. On the ears and cheeks was an inflammation more like ordinary eczema. There was also a chronic inflammation of the eyelids of both eyes, for which the patient had been under treatment for a considerable time at the Ophthalmic Hospital, Moorfields. There was also chronic inflammation at the margin of one nostril.

The lymph-glands of the neck, under the jaw, and at the sides of the cheeks, in front of the ear, were enlarged and hard, but none of them had suppurated.

The skin of the rest of the body was healthy, and there was no sign of pulmonary disease.

The diagnosis was evidently destructive folliculitis, complicated with diffuse inflammation, also suppurative and destructive, and with some ordinary, perhaps seborrhœic, eczema.

The general condition clearly pointed to some constitutional affection, such as tubercle of the scrofulous type, or inherited syphilis.

Of tubercle, though the general appearance of the child was what is generally called scrofulous, there was really no evidence. The enlarged glands had never softened or suppurated, notwithstanding the long duration of the disease, and there was no evidence of any visceral or arthritic tuberculosis.

The evidence for hereditary syphilis was carefully examined. The

teeth were suggestive, though not absolutely diagnostic of this affection. The upper central incisors were normal; the second incisors were narrow and conical; the upper canines only remarkable in being rather short. The lower incisors were short, stunted, and separated by wide gaps. There was no deafness; the corneæ were clear, and no scars could be detected round the mouth. Notwithstanding the absence of that affection of the central incisors on which Mr. Hutchinson lays so much stress, and of other confirmatory evidence, the general appearance seemed to me to indicate late hereditary syphilis; and this was remarkably corroborated by subsequent evidence, and by the results of treatment.

Family History.—Patient was the third of ten children, all of whom are still living; the eldest was said to be quite healthy; the second had had ulcers on the eyes, evidently ulcerative keratitis. The remaining seven were said to be healthy, but I never saw any of the other children. There was no history of miscarriages.

The father and mother were said to be healthy. However, some two or three months after the child was admitted (and when anti-syphilitic treatment had been already commenced), the father accompanied the child to the hospital, and a single glance at him at once showed the true state of the case. He was a tall, powerful man, but showed on his forehead some formidable scars, evidently due to tertiary syphilis; and some similar bald scars on the head. It appeared he had been in the army and had had primary syphilis, for which, he says, he was not treated. He was free from the symptoms for some years, and then married; but about nine years from the primary disease he had an affection of the scalp and forehead which left the scars above mentioned. He was treated and completely recovered, having had no sign of disease since. But quite recently (January, 1895) he has applied at the hospital for patches on the head, which are evidently a recrudescence of his old complaint. It is a suppurating, encrusted syphilide of the scalp, evidently such as would produce scars like those which have already been noted. The glossy atrophic scars are, I may say, something like those on the daughter's head, but there is, in the father's case, no folliculitis.

It is noticeable that the date given for the outbreak of tertiary symptoms in the father coincided broadly with the appearance of hereditary syphilis in his family.

He stated that he had these symptoms about 1875, and they lasted some months. The second child, with ulcerative keratitis, must have been born about 1876, and our patient was born in 1877; so that these would be the only children born or begotten while the father was thus suffering. It may also be noted that the inherited disease in this patient (and probably in her sister) was distinctly of a tertiary character (as usual in late hereditary syphilis), and that there was no history of any infantile affection, though such may possibly have been overlooked. This seems to me a fact in favour of the belief that the character of the lesions of hereditary syphilis is influenced by the stage of the original disease in the parent from whom the inheritance has descended, and also shows the greater chance of hereditary transmission at a time when the disease is active in the parent than in intervals of latency.

Treatment.—When the child was first seen, a dilute nitrate of mercury ointment with creosote was applied locally, and phosphate of iron internally. Under this treatment, which was continued for one month, no improvement was noted either in the local disease or in the general condition. Being convinced of the fact of syphilitic inheritance, I then prescribed Iodide of Potassium, first in three-grain and afterwards in ten-grain doses. There was an immediate improvement both in the local and general condition, which was still more marked when mercury (Hydrarg. cum cretâ gr. ij) was also given. Afterwards a mixture of Perchloride of Mercury, first alone, and then with Iodide of Potassium, was substituted. In brief, the effect of this definite anti-syphilitic treatment was unmistakable. First the general nutrition improved, the child became fatter, and the colour returned to her cheeks, than which there can be no clearer evidence of the benefit of mercurial treatment. Then the local lesions gradually disappeared, so that on June 29th it was noted that the greater part of the head was healed, but some follicular suppuration and crusts remained. The lymphatic glands also much diminished in size. Notwithstanding interruptions in the treatment (the child lived more than thirty miles from London, and only came up about once a month), the improvement was so marked that in October it was noted, "most of the scalp clear; no suppuration; only some scaly patches." Relapses however occurred in the course of

the next year, and it was two years before the head could be pronounced perfectly healed.

It may be worth noting that no local treatment was of much avail. Most of the remedies tried, such as various mercurial ointments, coal tar solution, creolin, sulphur, boric acid, either did no good or aggravated the inflammation. That which was most useful was an ointment containing iodoform. These results are decidedly against the assumption of a parasitic cause for the disease, and confirm the diagnosis of syphilis.

Condition after Treatment.—The girl has now a good growth of hair on the front, sides, and back of the head, but the bald vertical patch is quite unchanged, the hair-bulbs being entirely destroyed. Her general appearance is entirely altered. There is little or nothing in the physiognomy to suggest hereditary syphilis, and she is a well-nourished healthy-looking girl.

CRITICAL DIGEST.

DR. UNNA'S HISTOLOGICAL PATHOLOGY OF DISEASES OF THE SKIN.

(Continued.)

IF there were any hopes that in this work the perfect classification would be found, these will be disappointed. That promised land still remains to be discovered, and, as will be seen on reading the book, the divisions here are very largely supported and based on the histopathology of the various conditions.

It begins with anomalies of circulation, and is divided into six main groups:—1. Anomalies of circulation; 2. Inflammations; 3. Progressive disturbances of nutrition; 4. Regressive disturbances of nutrition; 5. Mal-formations; 6. Saprophytes and foreign bodies. These divisions vary in size from No. 6, which consists of five pages, to No. 2, which contains nearly 600. The group of inflammations contains practically all the commoner skin diseases, such as eczema, psoriasis, impetigo, erythema, lupus, etc., etc. The finer division is, as already indicated, mainly histo-pathological, and one form of syphilitic eruption appears under a sub-group of "chronic neurotic erythema," while the rest of the disease is treated under the section "local inflammations of the corium with a tendency to the formation of tumours, and with the power of becoming general." In the first section, on anomalies of circulation, Auspitz's group of *erythanthema* is adopted, while the erythemata come under the neurotic inflammations. Most interest will no doubt attach to the chapters on eczema, on which Dr. Unna's views have attracted so much attention. He recognizes no series of stages as do the majority of text-books;—papule, vesicle, etc.—but regarding the disease as an infective one, he finds that histologically it is distinguished by four characters: *parakeratosis*, *acanthosis*, *spongy transformation of the epithelium* and the *formation of vesicles*, and *certain changes in the connective tissue*. A further histological fact, and which he regards as invariably present,

is his *moro-coccus*. Further, he recognizes a number of *conditions*, such as spongy, hyperkeratotic, pruriginous, etc. Dr. Unna's views on seborrhoeic eczema are too well known to require any explanation, but I might note in passing his very definite statement that rosacea is, in the vast majority of cases, seborrhoeic in origin, and has nothing to do either with the drinking of tea or any digestive disturbance. Another point is cleared up. Those of us who have visited Eimsbüttel have often been somewhat startled to hear cases of what we would call typical psoriasis described as seborrhoeic eczema. While "the venerable old name"—I use his own words—is still retained, Unna pretty plainly indicates that he regards psoriasis only as the extreme development of a dry eczema. In discussing Darier's disease, he takes his stand definitely beside Boeck in denying the coccidial nature of the structures there found. The chapters on lichen are very interesting both in the very suggestive discussion of the histology, which still requires much investigation, and in the almost ferocious rending asunder of Kaposi's views on Lichen moniliformis.

Among the inflammations of the follicles, acne is the only condition to which Unna applies the old name. The others, acne varioliformis, necrotica, etc., are rechristened *folliculites*. Favus and ringworm, though they are not confined to the follicles, are described under this heading, while Pityriasis versicolor and Erythrasma are found in the section on Saprophytes at the end of the book. This is merely another indication that the basis of classification is histological and not etiological. Another disease which takes its place among the folliculites, is our old friend Lichen scrophulosorum, for the author does not consider the evidence of its tubercular nature sufficient. While not denying the existence of inflammations of the coil-glands, Unna points out that the cases must be very carefully and critically examined. Among local infectious inflammations of the corium, the description of erysipelas is particularly good, and Unna's views are not altogether in accord with those in favour in high places, for he finds no evidence of a victory of the phagocytes over the cocci, but that if there is any question of victory, it is the cocci which are the victors. His description of white erysipelas, and his caution regarding its danger, are also of value. Lupus, which is described as "an inflammation of the skin with a

tendency to the formation of tumours, and capable of becoming generalized," is put in its proper place as *Tuberculosis vulgaris cutis*, the typical primary tuberculosis of the skin, while the condition which has been unduly elevated under the title of "true" (?) tuberculosis of the skin is relegated to its proper place at the bottom of the list as the tubercular ulcer. On leprosy Unna's views are familiar, though probably in none of his many interesting investigations has he found so few to follow him as in this connection.

Malignant tumours of the skin occupy over a hundred pages, and are discussed in a very interesting manner, carcinoma being described under six varieties, one of which, *carcinoma vulgare*, contains no fewer than eight sub-varieties. With regard to rodent ulcer, Unna seems to indicate that one of the reasons why the disease is not recognized in Germany is that it is exceedingly rare; but, as usual in this connection, there at once arises the question of what is a rodent ulcer, and though the author and I agree over a certain number of specimens as being quite clearly rodent ulcer, there are some over which we are by no means in agreement. As to their origin we again differ, for Unna does not accept the sweat-gland theory. But do not let the sebaceous-gland theorists think that they have got a valuable recruit. Unna derives most cancers of the skin from the epidermis itself, not directly, but in a most ingenious and interesting manner, for which the reader must be referred to the original. The section on nævo- and melano-carcinoma will be read with interest by all, and I share his view, that pigmented tumours are very frequently carcinoma.

Under the section of malformations, we have the various forms of Nævi, a word whose significance is so very different in German and English, that I may do well to explain the meaning in which Unna uses it. Nævus in German is practically synonymous with the English expression "mother's mark," and includes warts, moles, etc., as well as what we call nævi. Some definite idea of these common structures would be of great value, but they are so common that none of us seem to think them worth the trouble of investigating. In comparing the meaning of the German Nævus to the English "mother's mark" I must not be taken too literally, for Unna describes a *seborrhæic nævus*, of course not congenital.

To suppose that the innumerable new ideas will all be accepted,

would of course be absurd—probably even the author himself will hardly expect that—but they are all of them interesting, and well worth investigating. Some scoffers will no doubt be found,—it is so much simpler to throw ridicule on any new view than it is to take the trouble to investigate it,—but, from a knowledge a good deal closer than that of the ordinary reviewer (I have translated nearly half of the work into English), I can testify to the great value of having at hand such a work as this in making clear one's descriptions of the nature of skin diseases to large classes of students. The absence of a number of drawings is a distinct want. There is a coloured plate at the commencement of the book, but it is chiefly, indeed entirely, concerned with the various changes *in the cells*. This fault, however, will almost certainly be corrected in the English edition of the book. The work will be of interest, not only to the dermatologist, but it contains much to interest the general surgeon, the pathologist, and the bacteriologist. One caution, in conclusion, to prevent disappointment. Any one taking it up merely to glance over, will certainly be disappointed, for he will find that a large amount of it is—I can hardly say Greek, if that is to be the language of medicine in the future, but some—unknown tongue to him. The book requires to be read, but no one with any knowledge of Dermatology will, if he reads it, think his labour in vain.

NORMAN WALKER.

SOCIETY INTELLIGENCE.

DERMATOLOGICAL SOCIETY OF LONDON.

At an ordinary meeting of the Society held on Wednesday, March 13th, 1895,

Dr. H. G. ADAMSON showed a well-marked case of *multiple Lupus verrucosus* in a boy, aged three years, of Polish-Jewish origin. The eruption was said to have appeared during an attack of measles when the child was two years of age. The lesions were asserted to have developed simultaneously, and according to the mother's statement there have recently been no fresh lesions, although those present have increased in size. The child was well-nourished and in good general health, although very "cross and fretful." No family history of tuberculosis was elicited. There were no subjective symptoms. The lesions were raised, purplish-brown patches, varying in size from a tenth to a quarter of an inch in diameter; they were hard to the touch and sharply defined, with almost perpendicular edges. Many were scaly, and those on the hands exhibited considerable wartiness. They were situated in greatest abundance on the tip of the right elbow, the right wrist and hand, on both knees, and on the right ankle and foot. The mucous membranes were unaffected.

Dr. ALDERSMITH exhibited a child who had suffered from ringworm for two and a half years. When first seen by him, a year ago, the scalp was almost covered with tinea (*Tricophyton megalosporon endothrix*, of the *resistant* variety).

Treatment with sulphur and white precipitate ointment for six months made no impression on the disease, and six months ago the head was still almost completely covered with tinea. Gas-water (sulphide of ammonium, with an excess of ammonia) was ordered. After four months' treatment there was a great and peculiar change. Very many of the diseased stumps had fallen out, but hundreds of

them had atrophied, and there was a complete mixture of ordinary thick ringworm stumps, and atrophied stumps. The former easily broke off, leaving the root part in the hair-follicles, and when examined they were found to be saturated with the *tricophyton*. The atrophied stumps, on the contrary, easily came out with entire small roots, and were similar to the atrophied stumps commonly seen in alopecia areata. Most had some brown pigment in the centre, and at the ends. Some had distinct bulbosities, and when broken off at these places, the ends were frayed out like stumps from true alopecia—many having the usual (!) shape.

By this time the scalp was semi-bare, and had a very curious appearance, many long normal hairs being present, but there were hundreds of these atrophied stumps, as well as many diseased and thickened stumps also.

On carefully examining a number of these atrophied stumps, most were found to be quite free from the *tricophyton*, but some had chains of the mycelium-spores just at the free end of the stump, showing that these atrophied stumps had formerly been diseased hairs; but, from treatment, atrophy of the roots had come on, the fungus had ceased to grow into the bulb, and thus by degrees the stump had grown up a little, with the end near the bulb quite free from the *tricophyton*, though a few chains remained at the distal end.

In five and a half months there were still many hundreds of the atrophied stumps to be found, and a very few diseased hairs, but numerous fine downy hairs were growing. The case was then seen by Dr. Colcott Fox, and both observers found the *tricophyton* in the distal ends of some of the atrophied stumps.

On the day of exhibition Dr. Aldersmith had most carefully examined the child's head; and, while finding the hundreds of atrophied stumps now to be seen, could detect only a very few genuine ringworm hairs. One was exhibited under the microscope, showing the hair to be saturated with the large-spored variety of the *tricophyton*.

The exhibitor said he had seen this curious result a few times from treatment, chiefly from boracic acid, ether and spirit lotion, and also from gas-water. If it could only be produced it was a good way of curing ringworm; for, if the diseased hairs could only be caused to atrophy, the fungus seemed to die out, and the atrophied

stumps come away ; and, when the case is put under a stimulating plan of treatment, the new downy healthy hair soon grows, and the case is cured.

Dr. Aldersmith considers true alopecia areata to be quite a distinct affection from this artificially produced form ; that genuine alopecia has nothing whatever to do with tinea tonsurans ; and that it is the occasional production of "bald ringworm," with stumps like the atrophied stumps in alopecia areata, and a few diseased stumps containing the true fungus of ringworm, that has led to the erroneous opinion that there is a fungus present in some forms of alopecia areata, and that sometimes true alopecia areata is a contagious disease.

He considers that if the characteristic fungus can be detected under the microscope, it is a clear proof that the disease is true tinea tonsurans, no matter how bare the places may have become ; and he has often seen patches of tinea pass by degrees under treatment into bare white spots, with (!)-shaped stumps, that could not be distinguished in the later stages from true alopecia areata, except by the history of the case.

Dr. JAMES GALLOWAY showed a case of *chronic exfoliating Inflammation affecting the lower lip*.—The patient was a single woman of forty years of age. The lip is always somewhat swollen and protruding, and the red surface is covered constantly with a dry brownish epithelial crust. At present the crust is not of great thickness, but occasionally during exacerbations of the disease the crust covers the whole of the red part of the lower lip to a thickness of about half an inch. On removing the crust the surface of the lip is dry, somewhat glazed, and shows a slight tendency to crack, but never to ooze or bleed. This condition has lasted for fifteen years, and has been under the exhibitor's observation since June, 1891, when she was sent to the Great Northern Hospital by a medical friend who despaired of producing any change in her condition by treatment.

In addition to this trouble the patient suffers much from dyspepsia, digestion progresses slowly and with difficulty, and constipation is sometimes exceedingly troublesome. She is of a neurotic temperament, and is at times very irritable and depressed.

The excretion of the mucous and salivary glands in the mouth

seems to be altered in character. Their secretions seem very viscid, so that the mouth is always uncomfortable and dry. Tartar deposits on the teeth with great readiness, and has to be constantly removed.

Numerous methods of treatment have been adopted, both general and local, but with very little effect. She improved most when on one occasion she was admitted to the hospital, and one was able to make sure that the mouth and lips were constantly attended to, making use of sedative and mildly astringent local applications.

Dr. Galloway said the condition had always been mysterious to him, and having seen no other case like it, he felt much at a loss how to classify or treat it. It seemed to correspond most closely to the cases mentioned by Besnier and Doyon as "*eczéma exfoliant des lèvres*."* As in their cases, so also in the present, there is a tendency to seborrhœa of the face and scalp, and the patient also is a woman "*à névrosité accentuée*." The experience of these authors agrees with the exhibitor's that the disease is permanent, having exacerbations and remissions, which cause "both the patient and the physician to constantly alternate between conditions of hopefulness and disappointment."

His attention had been drawn by Dr. J. J. Pringle to the cases of so-called *Cheilitis glandularis*, described originally by Volkman, of Halle, and mentioned by Dr. Purdon, of Belfast,† who has also had experience of four cases. In these cases there appears to be an affection of the cheek and jaws, just as in the patient shown. On the other hand, the hypertrophied condition of the mucous glands, which is apparently so noticeable in Volkman's and Purdon's disease, is absent in this case.

Mr. JONATHAN HUTCHINSON showed a case of *Infective Angioma on the Hand (Nævus-Lupus)*.—The subject of this case was a girl, aged twenty-one, of whose hand two portraits had been taken some years ago, which were shown. The original condition in early childhood was that of two nævoid patches in the skin of the back of the hand, between the thumb and forefinger. They were about the size

* "*Maladies de la Peau*." Kaposi, Besnier, Doyon. Paris, 1891. Vol. I., p. 665.

† *British Journal of Dermatology*, Vol. V., 1893, p. 23.

of two sixpences, and were placed near together, with a third about the size of a pea close to them. Although certainly nævoid in part they were not purely so, for their surface was rough, and had a dry adherent scale crust. They had originated in early childhood, and had not been present at birth. The disease was clearly aggressive and "infective," and two of the patches were no doubt "satellites" to the other. The first portrait showed very accurately the condition of things in 1884. A second portrait taken in 1887 showed a recurrence of the nævoid condition in the scar that had remained after a very efficient cauterization, which had been performed in the hope of cure. Although the scar was sound it was stippled over with tufts of dilated blood-vessels, almost black in colour, exactly like, excepting in point of tint, the vascular scars left after lupus on the face and scalp. At the present time the girl's hand showed a condition of acute inflammation around the patches which had occurred in connection with the recent cold weather, and a slight bruise which had been received. The patches had also increased considerably in size. The girl had no skin disease elsewhere.

Dr. J. J. PRINGLE (1) showed a lady, aged 28, who had been brought to him in consultation the same afternoon by Dr. Thornton, of Acton. At the age of eighteen she began to suffer from *Chilblains* in frosty weather, and these recurred every winter for five years, but cleared up entirely in summer. At the age of twenty-three the patient married, and her chilblains were more severe than ever in the ensuing winter. After the birth of her only child, at the age of twenty-four, she was free from trouble throughout the winter. The condition, however, relapsed, and during the last four years traces of the disease have persisted throughout the summer in the form of erythematous, infiltrated discoloured patches on the hands. Both paternal and maternal grandfathers suffered severely from classical gout, and the patient herself is very liable to muscular rheumatism in damp weather, although she has had no arthritic mischief. There was no tubercular family history. Her hands and feet are always either hot or cold, and her ears burn and are congested.

Dr. Thornton had noted that the "chilblains" presented certain unusual characters, viz., they were definitely circumscribed, with very little surrounding erythema; they were much infiltrated, with

abrupt margins; they were slightly hard to the touch, and never ulcerated; although most abundant on the dorsal surface of the hands and feet, several were also present on the flexor aspect of the fingers and toes. The colour of the larger plaques was pinkish-purple, and this was especially noticeable in a large one situated on the back of the left hand, which was said to have persisted unchanged throughout the past year. The appearance of the hands was suggestive of the condition described by Radcliffe-Crocker as *Erythema elevatum diutinum*, but the lesions were not so hard to the touch, nor so nodular.

The face presented patches of erythema with seborrhœa and desquamation (*Seborrhœa congestiva*) over the tip of the nose, and symmetrically over the malar prominences and the lobules of the ears. Those in the "flush-patch" situations had been persistent for a year, but the others were said to disappear from time to time. Neither on the face nor extremities were there any signs of scarring.

All the members present agreed with the exhibitor in regarding the case as a poorly developed form of *Lupus erythematosus*, and as exemplifying the relationship of that disease to "chilblain circulation" and persistent forms of erythema.

Dr. J. J. PRINGLE brought forward (2) the case of *Actinomycosis* extensively involving the skin, shown on a previous occasion (October 10th, 1894), and published in full with coloured illustration in Vol. 78 of the *Medico-Chirurgical Transactions*, 1895. The lad, aged 13, had undergone a most remarkable degree of improvement under treatment with iodide of potassium in as large doses as he could tolerate, viz.: fifteen grains, three times a day. From time to time it had to be discontinued, as it caused diarrhœa, vomiting, or bronchitis. Nevertheless his general condition had materially improved; he had gained 7 lbs. in weight; the sarcomatous-looking masses on the back had "withered" down to the level of the skin, and had, for the most part, become passive, while in the purulent discharge from the few still active, no ray-fungus could be discovered. The urine contained 75 per cent. of albumin, which the exhibitor considered as probably the result of direct actinomycotic invasion rather than of amyloid disease, as there were no tube-casts, and no evidences of enlargement of the spleen.

Dr. GALLOWAY stated that he had recently made an autopsy on a

fatal case of Actinomycosis treated by large doses of iodide of potassium, and that attempts to find ray-fungus in the purulent discharge were unsuccessful.

Dr. STEPHEN MACKENZIE mentioned that the case of Actinomycosis he had recently shown to the Society (November 14th, 1894) had succumbed to the disease.

Dr. J. J. PRINGLE showed (3) a man aged 50, by occupation a missionary, suffering from a peculiar form of *Folliculitis decalvans*, affecting the scalp, eyebrows and beard. He came under observation on August 4th, 1891, and had been seen from time to time ever since. The notes made in the first instance were to the following effect:—His general health was good, and there was no suspicion of syphilis in his appearance or history. In 1886 he had been treated for "eczema" of the limbs and trunk, his description suggesting the possibility of his having had a "patchy folliculitis" of those parts, although no pitting or scarring indicated the former sites of disease. His scalp had been affected since 1883, the condition first manifesting itself at the vertex. In 1888 his eyebrows and beard became simultaneously affected. All the diseased parts were the seat of extreme irritation and soreness—not of itching—for the relief of which he had been in the daily habit of epilating the recently affected hairs. The disease on the scalp spread from before backwards, the patient being almost completely bald so far back as a line running transversely from ear to ear. In front of this line the scalp was tense, smooth, very densely studded with tiny, atrophic, white, thin pits or scars, giving the part a finely stippled appearance. Behind this line were evidences of recent disease, extending back over the centre and adjacent part of the scalp as far as the superior angle of the occipital bone. Here the baldness was only partial, and the essential lesions, which were in greatest abundance immediately behind the line referred to, diminished gradually from before backwards. These essential lesions were noted as being small, acuminate, follicular papules and vesico-pustules, the centre of each of which was penetrated by a hair which could be easily and painlessly detached with forceps. The roots of the hairs were infiltrated and swollen, and dried scab formed a collarette round each hair-shaft. (No microscopic examination was made.) Surrounding each element was a narrow, vivid, erythematous zone, and in the regions where these were sufficiently abundant to

coalesce an "eczematoid" appearance resulted. An exactly similar condition obtained in the eyebrows, which were partially bald. The moustache was unaffected, but he had considerable folliculitis of the beard without marked baldness, a fact which he attributed to his being able to epilate more successfully there than elsewhere.

The idea strongly suggesting itself that the disease was of parasitic origin, he was ordered a creolin lotion and resorcin paste, with daily epilation of the spreading margin of the disease. Subsequently these were replaced by a perchloride of mercury lotion and salicylic acid ointment, and recovery was almost complete in April, 1892, when he had an acute relapse, although under regular and systematic treatment. The pustules then averaged about the size of a pin's-head, and the hair fell out in great abundance spontaneously. Since that time he has had intervals of quiescence of the disease with occasional slight relapses, but he has ceased to follow strict treatment.

No member had seen a similar condition. It presented some resemblance to *Acne varioliformis* (*vel necrotica*), but the elemental lesions were all follicular, the patterning was much finer and closer, the pitting less marked and shallower, the baldness more extensive, and the distribution dissimilar.

Dr. J. J. PRINGLE next brought forward (4) two water-colour drawings and a case shown at a previous meeting, December 12th, 1894, regarding which opinions were divided as to its being an instance of *Tuberculosis* or *Sarcoma of the skin* of the feet and legs. The ulcerated surfaces had been freely scraped, skin-grafts had been applied according to Thiersch's method, and rapid recovery had ensued. Microscopic sections of excised nodules were exhibited, which showed the appearance of an acute inflammatory affection of the upper layers of the cutis. There were no appearances suggestive of a tuberculous process. The nature of the case is still a matter of the greatest uncertainty, no member present being familiar with a similar one. It will be further investigated.

Dr. J. J. PRINGLE exhibited (5) a woman, aged 57, who had been under observation for many years for *Rosacea*, but whose general health was fair up to a year ago, when she had a severe attack of *Influenza* accompanied by much pain in the head and limbs. Ever since she had been subject to *localized Sweating*, accurately confined to the area of distribution of the two upper divisions of the *right fifth*

nerve, and of the *auriculo-temporal branch of its third division*. The sweating, which was very profuse when under the influence of emotion, was unaccompanied by pain or other forms of disordered sensation.

Dr. J. J. PRINGLE showed (6) a severe case of *Acne scrofulosorum* in a big flabby girl, aged 16, with no tubercular family history, but with enlarged cervical glands. The eruption appeared eight weeks previously as numerous "boils" on the face, which rapidly spread over the trunk and limbs until the whole body was covered with spots. The lesions, which were intermingled with ordinary acne pustules and comedones, were extremely numerous, developed in crops, suppurated freely, and left deep livid blue scars, most noticeable over the buttocks and thighs. The arms were also deeply pitted.

Dr. J. J. PRINGLE showed (7) a girl, aged 22, exhibiting peculiar and deep scarring on the legs, *for Diagnosis*. The scars, which were with one exception confined to the left leg, were very deep, of a peculiar tallowy white colour, and their margins were studded with large telangiectases. They were the result of "ulcers" which developed in Dublin five years previously, which discharged copiously, and for which she was for some weeks in Hospital. On the back of both hands and wrists she had severe ulcerating chilblains, and she had just recovered from an attack of lymphangitis (?) of the most severely affected leg. Despite the absence of tubercular family history and of distinct scrofulous stigmata, the majority of members concurred with the exhibitor that the case was probably one of Bazin's *Erythema induratum*. There was no suspicion of congenital or contracted syphilis.

Dr. STOWERS brought forward the case of John P., aged 29 years, formerly a grocer's assistant. In the early part of 1886 a *rodent Ulcer* was discovered on the left temporal region immediately in front of the hair of the scalp. The ulcer was scraped in Dublin (prior to 1891), but without entirely removing the disease. During March, 1898, the patient submitted to excision, a considerable margin of sound skin being included in the operation, since which date there has been no return of disease. The cicatrix has a limited cheloid thickening in the centre, but in every other respect is healthy and sound. The general health of the patient has improved considerably of late.

Dr. STOWERS exhibited (2) a female, aged 26 years, who had been

subject for several years to crops of common warts (*Verruca vulgaris*) upon the hands and forearms, and who, subsequent to an attack of scarlet fever, twelve months ago, developed numerous instances of the planar variety upon the face, especially the cheeks. Her general health was good. No other case of warts existed in the house in which she lived.

Dr. STOWERS also exhibited (3) a boy, aged eleven years, who had numerous common warts (*Verruca vulgaris*) upon the face, especially the cheeks, stated to have spread from a large sessile wart on the left hand. There were no others on the trunk, or extremities. His sisters and brothers were unaffected.

Dr. STOWERS showed (4) a girl, aged 13 years, who during the previous nine months had developed a complete *Alopecia* of the scalp, commencing over the left parietal bone, and wholly unassociated with injury or accident. The history of the case was that it occurred spontaneously without pain, or subjective disturbance of any kind, and was not preceded by any parasitic disease. Careful attempts had been made to discover fungus, but without success. A somewhat curious feature was that the eyebrows and eyelashes were unusually full and strong, and that dark pigmented hairs existed uniformly arranged over the whole of the upper lip.

THE DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND
IRELAND.

At the meeting of this Society held on Thursday, March 14th, Mr. GEORGE F. HENTSCH, and Mr. W. WINKELRIED WILLIAMS, were unanimously elected members.

MR. GEORGE PERNET read notes of a case of *acute fatal Pemphigus*. A. E. H., a journeyman butcher, æt. 32, was admitted to the Skin Ward, University College, under the care of Dr. Crocker, on the evening of March 2nd. At 7 P.M. on that day his temperature was 104.4°. I first saw the patient on the 4th of March, about 11 A.M., and found him in a very weak and serious condition. He was able, however, to give a connected account of his illness. About three months and

three weeks before his admission, he had noticed a tiny "gathering" on the little finger of the right hand. It did not trouble him, and remained the same for about three months. Nothing was done to it. On February 8th, a large blister suddenly formed round the lesion on the little finger. It was exactly the same in appearance as the blisters now to be seen on his body. It was raised quite half an inch above the level of the finger. The blister corresponded to the area of roughened skin, which can still be seen about the site of the lesion. The next day, February 9th, he came to the Out-patients' Department of University College Hospital, when the blister was treated like an ordinary whitlow. It was opened,* and fomented until February 11th, then an ointment was applied, and on the 16th the finger was practically right. On February 17th, the patient began to break out all over the body, the eruption beginning about the neck, behind the ears, on the back and scalp, in the groins and on the knees. He felt very bad as if he were going to die, and complained of shivering, back-ache, and pains all over. The bowels and micturition remained normal. On the 28th, blisters appeared on the tongue, lips, ears, and forehead. On March 1st, the eyelids were affected. Blisters appeared on the feet and hands after his admission. He attributed the original lesion on the little finger to a small wound inflicted in the course of his butchering work. A hard, horny nodule could be felt at the seat of the original gathering.

The patient on admission had been dressed with boracic acid ointment, but as the smell was extremely offensive, the dressings were carefully and rapidly changed. While this was proceeding I was able to make the following notes of the appearance of the skin :—The whole of the back is a sheet of reddened, blistered skin, with a very few islets of healthy skin about the sides of the thorax. About the upper part of the back there are raw areas here and there ; lower down, and especially about the buttocks to below the gluteal folds, the skin is quite raw, and it bleeds readily when the dressings are removed. The smell is very offensive. The dorsal lesion *en nappe* is bounded in a sinuous manner, and beyond its limits there are discrete old lesions produced by the bullous eruption, spreading thence down the arms and thighs. On the back of the thighs there are numerous old lesions and broken-down bullæ. In front, the groins are quite raw,

* The dresser states the contents were clear.

in a band-like manner, and the area of denuded skin reaches round to the dorsum. The scrotum is not affected; nor is the penis, as far as can be seen (copious smegma, and long phimotic prepuce). The inguinal glands are not enlarged. The thighs in front present discrete hæmorrhagic lesions about one-eighth of an inch in diameter. These are somewhat oval in shape. The front of the left knee is much more affected than the right, but the flexures of both are raw. The lower one-third of the legs and the dorsal surfaces of the feet present recent bullæ, with areolæ. Between the toes, on both sides, except between the fifth and fourth, the skin is denuded. The soles appear to be free and the skin somewhat thickened. There are some old discrete lesions, and subsiding and broken-down bullæ on the calves of the legs. There are also old discrete lesions on the arms. The inner surface of the left arm on the flexor aspect is denuded of skin. There are fresh and subsiding bullæ on the flexor surfaces of the forearms. The palms are free, as far as can be seen, but the skin is hard and horny. The left hand is a dull red to the end of the fingers on the palmar surface, and on the dorsum the redness affects the thumb and the index-finger only. The red area is well defined and somewhat raised. The same hand also presents recent bullæ on the dorsal surfaces of fingers. The neck is raw, as the result of bullæ which have broken down. There are blood-crusts about the lips, nostrils, ears, and eyes. Also raw areas on the forehead and about the inner canthus of the eyes. There is a purulent discharge from the eyes, and the lids have a tendency to stick together. The conjunctivæ are injected. The patient spits out a rusty, viscid secretion from the mouth. The mouth cannot be opened to any extent, and the tongue can only be slightly protruded. The scalp has been crusted, but has improved with poulticing. There are remains of old lesions about it.

The patient was delirious during the night of March 4th, and sedatives had no effect. On the 5th the patient was weaker, the pulse very feeble, about 142. That night he vomited three times, and ultimately died at noon on March 6th. The temperature had fluctuated between 104·8° and 98°. The urine was examined on the 4th and 5th. It was acid, about 10.25 sp. gr., presented a trace of albumen, but no sugar and no blood. The motions were normal, and no blood was found in them.

The post-mortem examination, made twenty-two hours after death, was negative. I took the opportunity of examining the skin lesions, before commencing the autopsy. The body was well-nourished, and of medium but good build. The back, from the nucha to below the gluteal folds, was raw, and presented here and there epithelial sloughs. Above, the raw surface extended from shoulder to shoulder, the width diminishing from above downwards, and corresponding to the parts in contact with the bed in the dorsal decubitus. Beyond the limits of this raw surface, there were broken-down, discrete lesions spreading round the body towards the ventral surface. The flexures of the knees were raw, to the extent of $3\frac{1}{2}$ by $2\frac{1}{2}$ inches. The elbows were also denuded. The palms were thickened, also the soles of the feet, but to a lesser extent. No trace of an eruption could be seen in these parts. No trace of lesions on the ocular conjunctivæ. There were ulcerations on the inner surfaces of the lips, and traces of old lesions on the hard palate. On the penis there were two small superficial ulcerations from $\frac{1}{4}$ to $\frac{1}{2}$ inch in diameter about the corona and on the glans respectively. No enlarged glands could be felt at the elbow and in the axilla on the right side, that is on the same side as the original lesion on the little finger.

About twenty-four hours after death, while rigor mortis was still marked, a tube of agar was inoculated from an unruptured, tense, recent bulla, with clear contents, situated on the left foot. Dr. Bulloch, Assistant to the Professor of Pathology at University College, has been kind enough to take charge of the tube and to examine the organism which is growing. He tells me that up to the present the mode of growth and the morphological appearances agree with the organism described by Demme* under the name of diplococcus of Acute Pemphigus. Dähnhardt,† in a case of Chronic Pemphigus, generally confirmed the views of Demme. In the present case, the growth of the organism on agar was slow at first. It grew rapidly when transferred to bouillon and plates. It is stained very readily by Gram's method, and this distinguishes it from the gonococcus, which it resembles morphologically, except that it is bigger. The bacteriology of the case will form, I hope, the subject of a further communication, as it promises to be interesting. It is, of course,

* "Verh. des Cong. für innere Medicin, Wiesbaden, 1886," p. 886.

† *Deutsche Med. Wochens.*, Vol. xiii., 1887, p. 711.

unfortunate that the inoculation was not done during life. It should be added that Demme did not find the organism he described in two cases of *Pemphigus Foliaceus* and Syphilitic *Pemphigus* respectively which he examined.

With regard to the etiology, it would appear that infection occurred through the lesion on the little finger. It is interesting to compare the present case with one of *Pemphigus vegetans*, published by Haslund,* of Copenhagen, in 1891. It is briefly as follows:—A woman, æt. 67, ran a splinter under her nail about October, 1889; supuration followed. In December bullæ commenced to appear. She died on March 25, 1890. Whether the patient in the present instance would have developed into a case of *Pemphigus Vegetans*, had he lived long enough, is uncertain.

I have not made inquiries with regard to the hygienic surroundings of the man's home, but it is as well to mention that he lived in buildings in Clerkenwell; I take it they were artisans' dwellings.

Another point about the etiology is the fact noted by Seaman, and other authors,† that a bullous eruption occurs in cattle. I do not know whether our patient had to do with hides or slaughtering.

The prognosis from the first was bad, the patient being evidently in a hopeless condition. The cases placed on record by Duckworth and Pitt died on the ninth and fourteenth days respectively. Southey and Payne's‡ patients recovered, as did also Demme's,§ a boy, æt. 18, in whom the greater part of the body was involved, but the soles and palms were free.

As to treatment, the patient was made as comfortable as possible by being placed on a water-bed. His mouth was frequently swabbed out, and the eyes were kept clean with boracic acid lotion. The dressings, boracic acid ointment and carbolic oil, 1 in 40, were changed as frequently as the condition of the patient would allow. He was too ill to be placed in a bath. He was ordered an effervescing quinine mixture, and his strength was kept up with milk, fresh eggs, and brandy. Demme states that he found anti-pyrim very useful in his case. Locally he used a hydroquinone oint-

* *Hospitals-Tidende*, Nos. 5 and 6.

† *Vide* Demme, *loc. cit.*

‡ Crocker, "Diseases of the Skin," second edition, p. 190.

§ Demme, *loc. cit.*

ment, 1 in 80, after trying antiseptic oils and lotions with little result. Antipyrin and hydroquinone, he states, also prevented the development of the organism in pure cultures.

It remains for me to thank Dr. Crocker for kindly allowing me to read these notes to the Society. I have also to thank Dr. Bulloch for the interest he has taken in the bacteriology of the case.

The following notes of a case of *Acute Nephritis with Uremia*, attended by an *Erythematous Rash* and *extensive desquamation*, were then read by Dr. STOWERS for Dr. WALDO, of Clifton:—

A female patient, æt. 17, by occupation a boot machinist, was admitted as an in-patient to the Bristol Royal Infirmary, 6th June, 1894, complaining of pain in abdomen.

Family history.—Father and mother alive and healthy, thirteen brothers and sisters all healthy.

Past history.—No previous similar attack. Has not menstruated for three or four months. No other illness.

Present illness.—Ten days ago patient noticed that her urine was very red. She had no pain when passing it, and felt no inconvenience from it in any way. She continued her work for five days before feeling ill. She then felt generally weary and tired; this was followed by sore throat. The urine became very scanty and of a dirty muddy colour, and the patient vomited several times.

Upon admission the temperature was 102° F. (in afternoon); skin dry, tongue coated, bowels very constipated, pulse 84, not very full; tension not great, heart's apex in normal position. A systolic murmur at apex and base. There was also a pericardial friction sound distinct at base. Urine 310 passed in 24 hours; sp. gr. 10.12, acid; albumen and blood were present, also granular and epithelial casts. Breath-sounds were harsh. No crepitations. There was general abdominal tenderness, but most marked in both lumbar regions, especially the right. Dull in both flanks when lying in any position.

A mustard-poultice was applied to the loins. The bowels were acted upon. A mixture of liq. ammonii acetatis was given, and also a hot-air bath.

Two days after admission the patient became very drowsy, and in

addition to the above treatment a hypodermic injection of pilocarpin hydrochlor., gr. $\frac{1}{8}$, was given. Much sweating was produced.

On June 12 (six days after admission) not nearly so drowsy. Urine much more in quantity. Pain much less. Sleeps more quietly at night. Urine contains less blood and albumen. Pericardial friction-sound more marked.

On June 15 (nine days after admission) an urticarial rash appeared on arms; the patches were raised, and some of them half an inch in diameter. The rash gradually extended to the body, face, and legs. It itches and burns. After lasting a week, this erythematous rash was followed by extensive desquamation.

The amount of albumen varied from .02 per cent. to .7 per cent.

The treatment mentioned above was continued till July 2, when some tinct. ferri perchloridi was added to the liq. ammonii acetatis. A few days after this the skin rash had entirely disappeared, and there was no albumen or blood found in the urine, which became quite normal. There was no audible cardiac murmur.

On July 21 a small lymphatic abscess in the axilla was opened, and the patient left the Infirmary quite well.

The case is interesting on account of the rarity of a skin rash in association with uræmia, and that the albuminuria entirely disappeared. The large majority of cases of acute nephritis resulting from cold, as far as I have noticed, go on to chronic albuminuria. There was no evidence or suspicion of scarlet fever in this case. I may say the diet consisted principally of milk.

Mr. MARMADUKE SHEILD showed a case of *Chancre of the Cheek* in a widow of 45, who had upon her left cheek an ulcer, with depressed centre about the size of a florin. There was marked infiltration and induration, and a bubo over the parotid and in the submaxillary regions. The patient stated that the ulcer began as a pimple two months ago. There was absolutely no history of infection, but a "coppery" eruption was fading away on the chest.

Dr. PAYNE exhibited a case of *Erythema induratum scrofulosorum*, or Bazin's disease of the skin. Man, aged 45, patient at the Hospital for Diseases of the Skin, cachectic; no positive sign of tubercular disease, but has had groups of enlarged lymph-glands, which have now

disappeared. One brother died of consumption. The left leg shows raised red patches, covering an area eight inches in vertical extent by six in breadth, somewhat indurated, which have spread in a ser-piginous manner, leaving pigmented patches. In the midst of the red patches ulcers have rather rapidly appeared. They are about the size of a shilling, with very abrupt walls, and heal slowly. There are now four, of which two are nearly healed. The disease has lasted nine months. Administration of iodide of potassium was of no use, but some cod-liver oil has been taken and there is a great improvement.

Dr. P. S. ABRAHAM showed a (1) case of *Leprosy* in a boy, æt. 11, who came from British Guiana in 1891, with coming symptoms of leprosy. He was shown that year at the Medical Society, and again the following year, with the maculæ and other symptoms practically gone. He has remained practically free and well until a fortnight ago, when a fresh dusky erythematous eruption appeared on the face, on some of the old positions and in new places. There has been no fever, but recently great lassitude, &c.

(2) A young woman, æt. 19, with bluish-red and slightly raised patches on both legs, chiefly on shins and calves of lower third. The larger ones rather scaly. One place broke last year, leaving indefinite scar and pigmentation. Commenced six years ago, before Christmas, and has remained and increased ever since, being worse in winter. Has always had chilblains in winter on feet, and lately on hands. No family history of phthisis or other constitutional complaint, and patient in every respect quite healthy. The case is probably one of *Bazin's disease*.

(3) J. B., æt. 78, with large symmetrical outgrowths from the alæ nasi, or Rhinophyma, coming six years ago as "warts." The affection is known by the surgeons as "lipoma nasi," but as all the skin tissues are hypertrophied, and especially the glands, it is rather of the nature of *Adenoma*.

(4) A case of *Prurigo* in a boy, æt. 10, with extensive pruriginous eruption on the arms, buttocks and thighs, of eight years' duration. Many of the individual lesions are large pustules. The mother states that the child had chicken-pox in infancy, and the eruption has been there ever since.

(5) A case of *Lupus* in a young woman, with superficial patches on both cheeks, nose, and ears. When first seen a month ago there was distinct "apple-jelly" growth. One of the patches has rapidly improved after two applications of pure carbolic acid. The eruption first appeared last September. She has chilblains on the extremities, and a family history of tubercle.

Dr. ALFRED EDDOWES showed the following cases:—

(1) A woman, æt. 31, who had lost a great deal of hair from *Seborrhœa*, which had affected her scalp for many years. When first seen by Dr. Eddowes her scalp was covered by dried secretion of a yellow colour, and the epidermis was in a warty condition. The patient had been under treatment some years ago for conjunctivitis of a chronic nature, which had destroyed her eyelashes, and was now under Dr. Dundas Grant's care for disease of the ear (external meatus). In Dr. Eddowes's opinion the seborrhœa of the scalp was closely connected with the condition of the eyes and ears, and he considered the case a most interesting example of a large series of similar cases which he had recently observed. The observation was new to him, and in his opinion of great practical importance.

(2) A child from Shadwell (an out-patient under the care of Dr. Dawson Williams), with patches of *Leucoderma* on the back, surrounding a deeply pigmented spot and a patch involving the whole of the right eyebrow, the lower half of the hairs being fine and white. The whole of the scalp was nearly bald, and there were here and there small patches of white hairs. The history seemed to indicate that it was an old case of alopecia, which had contracted ringworm more recently. Dr. Eddowes said he had found some rotten stumps and taken hairs for cultivations.

(3) A sailor with a very extensive eruption of *Lichen planus*, involving all parts except the head and neck. It commenced three months ago. The irritation was diminishing—it had never been extremely severe—and the colour was fading, apparently as the result of treatment which had been commenced a few days previously. Dr. Eddowes showed a section under the microscope stained by Dr. Phillips, cut from an obtuse nodule which had been excised for examination. It showed the characteristic infiltration of the cutis lifting up the epidermis. The hair-follicles were not involved, but

the epidermis immediately over the nodule was, and the horny layer had rather the appearance of mesh-work than that of its normally dense structure.

(4) A girl with *chronic Eczema*, affecting chiefly the backs of the hands and wrists in large circular patches, which were very irritable. It was generally worse in winter, though occasionally very troublesome in summer. She had been treated at several hospitals for it with some benefit, but it had never been cured. Dr. Eddowes had found a band of skin at the margin of the scalp about an inch wide, and running nearly from ear to ear, almost entirely denuded of hair, and here and there cicatricial. Though there were a few follicles inflamed, and the process seemed to be gradually advancing, the patient knew nothing whatever of the history of the lesion. She had been told by her mother that when a baby she had had eczema of the face. She did not know whether that had anything to do with it.

Dr. STOWERS exhibited a boy, aged twelve years, who had suffered for upwards of eight years from a patch of *Lupus vulgaris* on the centre of the left buttock. The disease is stated to have developed from a single tubercle, and is now circular in form, with a diameter of two inches, the usual characteristics being well marked.

Dr. STOWERS also exhibited a young woman, aged nineteen years, with *Lupus erythematosus* of the face, who had submitted with excellent result to treatment by linear scarification and carbolic lotion. The disease had recently developed upon other parts of the face, and was to be treated in a similar way. The scalp and ears were unaffected.

The President (Dr. PYE SMITH), Mr. BUXTON SHILLITOE, Mr. HUTCHINSON, and Dr. CROCKER took part in the discussions in addition to the exhibitors.

CURRENT LITERATURE.

THE TREATMENT OF PSORIASIS WITH LARGE DOSES OF POTASSIUM IODIDE, WITH REMARKS ON IODISM. DR. SEIFERT, privat docent in Würzburg. (*Archiv für Dermat. u. Syph.*, Bd. XXVII. Hft. 8.)

THERE are many theories on the nature of psoriasis, but not one settles the ætiology of the disease, still less forms a basis for successful treatment in all cases. Psoriasis can be cured successfully with external remedies: *e.g.*, Chrysarobin, β Naphthol, Anthrarobin (obtained from alizarin), Hydracetin (a coal-tar derivative), Hydroxylamin, Aristol, Euophen, Gallanol (anilide of gallic acid), Gallactophen (derived from carbolic acid, &c.), but a recurrence is not thereby prevented. Consequently we make use of internal remedies, *e.g.*, arsenic and potassium iodide, in the hope of so influencing the system that a permanent cure may result. Arsenic, about which opinions are so divergent, may be said to have failed as far as permanency of cure is concerned; as regards iodide of potassium similar opinions exist. Dr. Seifert, with the object of elucidating this point, gives us his experience in thirteen cases of psoriasis. Greves first suggested the administration of potassium iodide in large doses. Haslund treated a large number of cases, about fifty. Of these forty-six were cured temporarily, and four were much improved. He found that the average duration of treatment was seven weeks; the head and neck first recovered, then the trunk, and lastly the extremities; here the eruption persisted longest. As a rule no change occurred until some four weeks after continuous administration of potassium iodide, and then the integument rapidly showed signs of improvement. The amount given in males varied from 160 to 1,890 grms (340 to 3842½), in females from 526 to 1,828 grms. (3156½ to 3832), and in children from 277 to 1,520 grms. (369½ to 3880). It was given in plenty of water, and in one case Haslund gave 50 grms. 312½ in one day. In this case, however, signs of iodism supervened rapidly, headache, tinnitus aurium and palpitation. A noticeable feature in all cases was the acceleration of the pulse, but there was no other febrile symptom. Dr. Seifert quotes other dermatologists who have used the drug and come to opposite conclusions as to its efficacy. He believes, however, that its administration, combined with local treatment (chrysarobin) cures the disease more rapidly than either method alone employed.

Dr. Seifert divides his thirteen cases into three groups, on account of the action of the drug. All the cases, with one exception, were examples of psoriasis vulgaris; the exception showed palmar and plantar psoriasis as well as universal eruption. In two cases only the mother and the father suffered from the disease, in eleven it appeared after puberty. Seven were males and six females; all were healthy and well-nourished, with the exception, perhaps, of one female. Group I. contains two cases, both females; they showed distinct evidences of iodism; and in one case, owing to gastric disturbance, the drug had to be stopped during the disappearance

of the rash. The temperature was normal, but the pulse was as rapid as 128. Chrysarobin-traumaticin (chrysarobin 3j, liquoris gutta-percha 3j) was applied with benefit to the patches of psoriasis during the defervescence of the eruption. Group II. contains seven cases, four were completely cured by potassium iodide without any external application. In the remaining three chrysarobin expedited the cure. Group III. contains four cases completely healed under potassium iodide, and in each case the bodily weight was increased in spite of iodism.

Dr. Seifert then discusses the various symptoms produced by the drug. The presence of iodism with small doses .82 grm. (5 grains) and its absence in large doses 1 grm. (15 grs.) and upwards, he refers to the diuretic action of the drug. In cases of albuminuria where its excretion is interfered with, potassium iodide should not be given. As regards the multiform character of the skin eruption, of which he gives *in extenso* examples, he concludes that the severer eruptions—pemphigus, purpura—are more frequent than the slighter ones—erythema, papules. He does not accept Wood's theory that psoriatics tolerate large doses of iodide of potassium because psoriasis is a manifestation of attenuated inherited syphilis.

The writer does not recommend potassium iodide in all cases of psoriasis, or even to the exclusion of external remedies, but rather regards it as an adjuvant to our treatment of the disease, and of value in those cases where the general health is good, and the urine has been ascertained to be free from albumen.

FRANK H. BARENDT.

NÆVI IN RELATION TO CUTANEOUS NERVE DISTRIBUTION.

Dr. FELICIANI. (*Clinica Dermosifl. della R. Università di Roma*, Fasc. I., 1894.)

Dr. FELICIANI gives an account of three cases of Angiomatosis cutis, accompanied by coloured plates illustrating the affection.

The patients were two females and one male, and the nævi were situated in the distribution of the fifth pair of cranial nerves. In the first case the angioma was limited to the second division of the left trifacial. There was no history of such an affection in the family. The skin, as far as palpation was concerned, was quite normal. Under pressure the redness gave place momentarily to a colour somewhat darker than the normal skin. In this case the buccal and pharyngeal branches were not involved—*i.e.*, there was no nævus of the mucosa here.

In the second case the nævus involved the distribution of the second and third branches of the fifth on the left side. The skin implicated was distinctly thickened, especially on the lips. The caruncle of the left eye was twice the size of the other; both irides were normal as regards reaction and accommodation (which is quite in agreement with anatomical grounds). The mucosa of the lips on the left side was thickened, and in places almost warty. The teeth were normal, and mesially the reddened (nævroid) palatal mucosa of the left side was sharply delineated from the normal half. The figures show this admirably. There was no family history of such an affection.

The third case is that of a man who from birth has shown a vivid red patch on the left side, bounded superiorly by the inferior eyelid externally by a line extending from the outer canthus to the corner of the mouth, and mesially by the midline of the face. In addition there is a patch over the temporal region, one centimetre distant from the larger one. Under pressure the redness disappears, leaving a discoloured skin area. To the touch the skin is thicker and less elastic than normal.

Dr. Feliciani notes that these angiomata were confined to the left side, and that the second division of the fifth was implicated in all, and that where the third division was involved that part of the mucosa (supplied by the buccal and pharyngeal branches of the second division) was also the seat of the nævus in contrast to the distribution of the nævus when the second division alone was involved, as in the first case.

FRANK H. BARENDT.

THE REMOVAL OF TATOO-MARKS AND NÆVI WITH CHLORIDE OF ZINC. M. J. BRAULT (Société de Dermatologie e de Syphiligraphie, Paris. *Annales de Dermatologie et de Syphiligraphie*. January, 1895).

THIS method of treatment consists, "after asepsis of the region, in making, or rather re-making, by means of classical needles, a tatooing with chloride of zinc." The best strength of solution for use is one of thirty parts of zinc chloride to forty parts of sterilized water. If proper care be taken, the operation is not followed by any untoward inflammatory reaction. After a few days a superficial crust forms, which falls about the fifth to the tenth day, leaving, in favourable cases, a superficial and supple scar, which in course of time becomes almost imperceptible. The application is simple and rapid, is accompanied by no pain, and gives immediate and remote results which are very encouraging.

The delicate point in the operation consists in adjusting the amount of therapeutic action to the depth and nature of the tatoo-marks.

With superficial pigmentary nævi the operation is very successful, but with vascular nævi the results have been so far less good, though the author has had less experience with these cases. The method is dangerous unless carefully and scientifically carried out, *i.e.*, it may lead to suppuration and deep cicatrices.

H. G. ADAMSON.

NOTES ON TWO CASES OF MULTIPLE BENIGN PAPILLOMATA OF THE BUCCAL MUCOUS MEMBRANE. Dr. C. RASCH (of Copenhagen). (*Annales de Dermatologie et de Syphiligraphie*. Paris, January, 1895.)

THE author thinks that the etiology of this somewhat rare affection is suggested by one of his cases.

Both cases were children. In one of them, aged six years, there existed also warts upon the fingers. These appeared some two years before the affection of the mouth, and the child was in the habit of sucking her fingers. The microscopical appearances of the papillomata of the mouth were similar to those of the warts upon the hands, and it seemed probable that they had arisen by contagion.

It was not noted whether warts existed on the fingers of the other case. Rasch advises that in these cases, as well as such with similar growths in the larynx or nose, the hands of the children or of their nurses should be examined for ordinary warts with a view to deciding this question of etiology.

H. G. ADAMSON.

THIRD INTERNATIONAL CONGRESS OF DERMATOLOGY.

It is now definitely arranged that this important meeting shall take place in London in 1896, from Tuesday, August 4th, to Saturday, August 8th, both days inclusive. The difficulties arising from the danger of clashing with the Annual General Meeting of the British Medical Association, to be held in London this year in the first week of August, and with the next International Medical Congress, to be held in Russia, in August, 1897, have at length been satisfactorily settled. The subjects selected for discussion, with the names of the gentlemen chosen by the Executive Committee to introduce them, will shortly be published. The following is a completed

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MR. JONATHAN HUTCHINSON.

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- (a) BRITISH :—The President of the Royal College of Physicians.
 The President of the Royal College of Surgeons.
 The President of the Royal College of Physicians of Ireland.
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Dr. G. F. Duffey.
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 Dr. Allan Jamieson.
 Dr. Robert Liveing.
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 Dr. Pye-Smith.
 Dr. Hermann Weber.
 Dr. Wilks.

(b) FOREIGN:—

(1) *France*—Dr. Besnier, Prof. Fournier, Dr. Hallopeau, of Paris; Prof. Leloir, of Lille.

(2) *Germany*—Prof. Köbner and Prof. Lassar, of Berlin; Dr. Unna, of Hamburg; Prof. Neisser, of Breslau; Dr. Veiel, of Cannstadt.

(8) *Austro-Hungary*—Prof. Kaposi, Prof. Neumann, Prof. Lang, Prof. Hans von Hebra, of Vienna; Prof. Schwimmer, of Buda-Pesth; Prof. Pick and Prof. Janovsky, of Prague; Prof. Jarisch, of Gratz.

(4) *Russia*—Prof. Tarnowski and Dr. Petersen, of St. Petersburg; Prof. Pospelow, of Moscow.

(5) *Italy*—Prof. de Amicis, of Naples; Prof. Pellizari, of Florence; Prof. Campana, of Rome.

(6) *Norway*—Prof. Boeck, of Christiania.

(7) *Denmark*—Prof. Haslund, of Copenhagen.

(8) *Spain*—Prof. Castelo and Prof. Olavide, of Madrid.

(9) *Balkan States*—Prof. Kalindero, of Bucharest.

(10) *Turkey*—Zambaco Pasha.

(11) *Greece*—Prof. Joannu, of Athens.

(12) *United States*—Dr. Duhring, of Philadelphia; Dr. White, of Boston; Dr. Nevins Hyde, of Chicago; Dr. Bulkley, Dr. Keyes, and Dr. Fox, of New York.

(18) *Canada*—Dr. F. Shepherd, of Montreal; Dr. Graham, of Toronto.

TREASURER:

Mr. Malcolm Morris.

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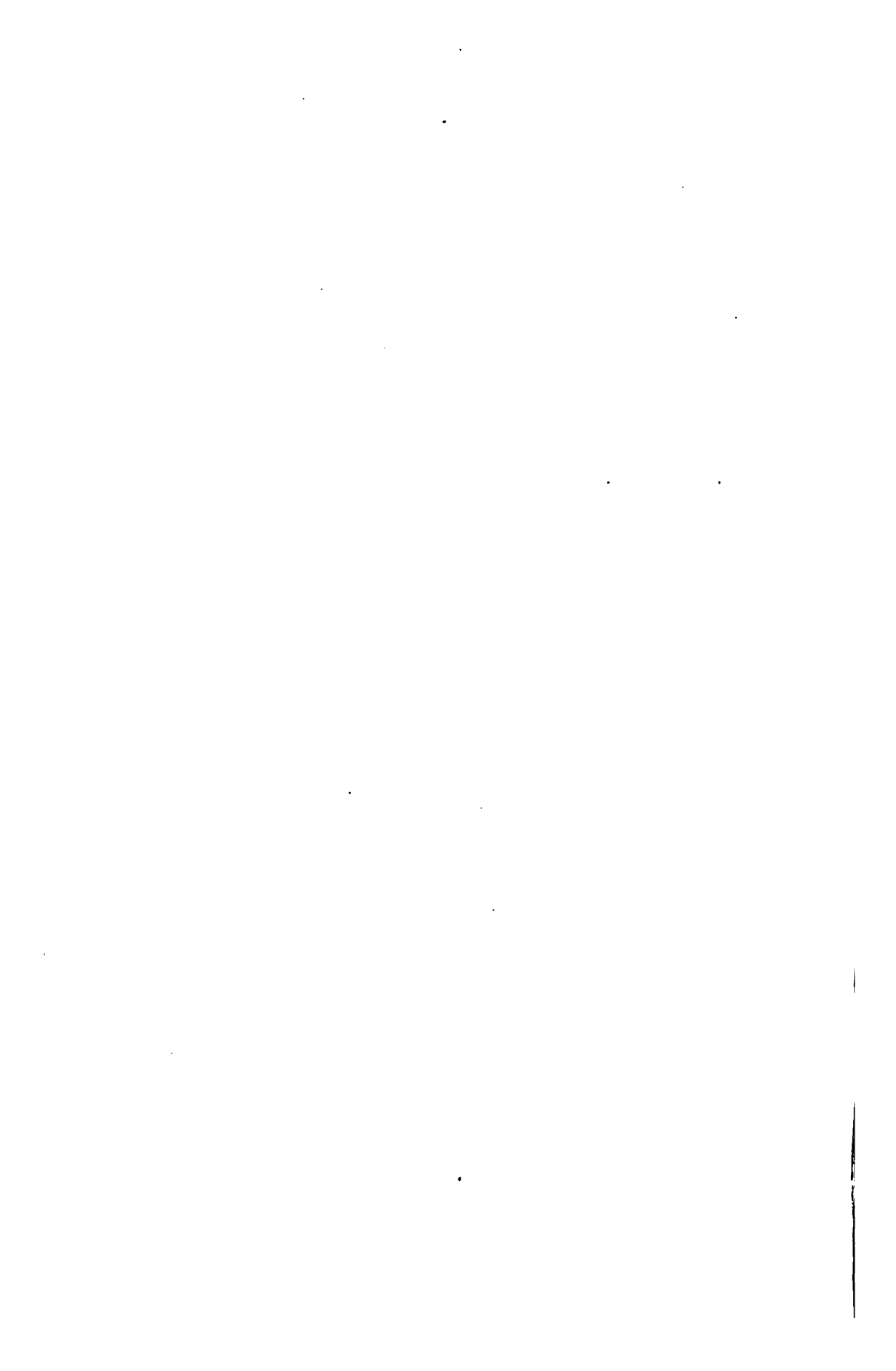
(b) *MUSEUM AND DEMONSTRATION*.—*Chairman*—Dr. Stephen Mackenzie. *Members*—Dr. Abraham, Mr. William Anderson, Mr. Hutchinson, junr., Dr. Perry, Dr. Stowers, Mr. Tay.

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Ex-Officio Members of all Committees—The President, the Treasurer, the Secretary-General.

SECRETARY TO SECTION FOR SYPHILIS:

Mr. Ernest Lane.





Mabel Green pinx^t

West, Newman chromo

M^r Hutchinson's case of
HYDROCYSTOMA AFTER HEMICRANIA.

FOREIGN SECRETARIES:

France—Dr. Feulard, of Paris.*Germany*—Dr. Rosenthal and Dr. Tænzer, of Bremen.*Austria*—Dr. Riehl, of Vienna.*Belgium*—Dr. Dubois Havenith, of Brussels.*Denmark*—Dr. Nielssen, of Copenhagen.*Hungary*—Dr. Török, of Buda-Pesth.*Portugal*—Dr. Zeferino Falcao, of Lisbon.*Holland*—Dr. Van Haren Nomann, of Amsterdam.*Sweden*—Dr. Welander, of Stockholm.*Switzerland*—Dr. Müller, of Zurich.*Italy*—Prof. Tommasoli, of Modena.*Spain*—Dr. Pardo, of Madrid.*Roumania*—Dr. Petrini de Galatz, of Bucharest.*Argentina*—Dr. Baldomero Sommer, of Buenos Ayres.*Australia*—Dr. Finch Noyes, of Melbourne.*Egypt*—Dr. Sandwith, of Cairo.*United States*—Dr. George T. Jackson, of New York.*Brazil*—Dr. Silva Araujo, of Rio de Janeiro.*Chile*—Dr. Valdés Morel, of Santiago.*China*—Dr. Neil Macleod, of Shanghai.*West Indies*—Dr. Numa Rat, of St. Kitts.

SECRETARY-GENERAL (from whom all information may be obtained):

Dr. J. J. PRINGLE, 28, Lower Seymour Street, London, W.

The following Regulations have been decided upon by the Executive Council:—

1. All duly qualified medical men, British or Foreign, or others interested in science invited by the Council, who shall have paid the fee of £1* sterling, and who shall have enrolled themselves, shall be Members of the Congress and entitled to the Volume of Transactions.

2. The official languages of the Congress shall be English, French and German, but with the permission of the President, Members may express themselves in the language with which they are most familiar.

3. The proceedings of the Congress shall be embodied in a volume of Transactions, edited by the Executive Council.

4. Communications relative to Membership, papers, or other matters connected with the Congress, should be addressed to the Secretary-General, Dr. J. J. Pringle, 28, Lower Seymour Street, London, W., or to one of the Foreign Secretaries.

5. The fee for Membership shall be payable in London, at or before the opening of the Congress.

It will greatly facilitate the work of the Executive if the fee is forwarded as soon as possible after the 1st May, 1895.

6. Members who are unable to attend the Congress shall receive the Volume of Transactions.

7. The subjects treated of shall be of two orders:—

(a) Those selected beforehand by the Executive Council and introduced by gentlemen chosen for that purpose by the Council.

(b) Those selected by individual Members themselves.

* The equivalent of £1 sterling is, French, 25 Francs; German, 20 Marks; Italian, 25 Lire; American, 5 Dollars.

8. Subjects selected for debate by the Council, shall take precedence over those selected by the Members.

9. The sittings of the Congress shall take place from eleven to one in the forenoon, and from three to five in the afternoon of each day.

10. There shall be Clinical Demonstrations of patients every morning from nine to half-past ten, and every afternoon from two to three.

11. Members contributing papers must submit an abstract of them to the Secretary-General, on or before the 1st May, 1895, which will be printed either in full or in part, and embodied in the general programme of the Congress which will be distributed at its opening.

12. At every debate precedence will be given to gentlemen who have communicated beforehand their intention to take part in it.

13. No papers lasting more than twenty minutes will be permitted. Speeches will be strictly limited to ten minutes each. MSS. of the papers read must be left with the Secretary-General before the end of the sitting. The Executive Council shall decide as to the entire or partial publication of such papers in the Transactions of the Congress.

GERMAN DERMATOLOGICAL SOCIETY.

THE next Congress of this Society will meet in Graz on September 23rd, 24th and 25th of the current year. The leading subjects will be "Pemphigus," introduced by Professor Kaposi, of Vienna, and D. O. Rosenthal, of Berlin; and "The Conduct of Tertiary Syphilis in its earlier stages to Therapeusis," introduced by Professor Caspary, of Königsberg, and Professor Neisser, of Breslau.

THE BRITISH JOURNAL OF DERMATOLOGY.

MAY, 1895

CASE ILLUSTRATING THE NEUROTIC ORIGIN OF HYDROCYSTOMA.

BY JONATHAN HUTCHINSON, F.R.S.

UNDER the name of hydrocystoma Dr. A. R. Robinson of New York has described a peculiar eruption occurring on the faces of women in middle and advanced life. Most of his patients were washerwomen, and he believed it to be in connection with exposure of the face to warm vapour and profuse local sweating. At a meeting of the American Dermatological Association in 1884 Dr. Robinson exhibited a portrait illustrating the condition described, and he stated that he had at the time four subjects of the disease under his observation. His observations were subsequently corroborated in a paper read by Dr. G. T. Jackson, published in 1886 in the *American Journal of Cutaneous and Venereal Diseases*, and illustrated by another portrait. Dr. Robinson had in the first instance called the disease "sudamina," and Dr. Jackson called it "dysidrosis." It had appeared to be a tolerably frequent affection in New York, for Dr. Robinson says that he has seen thirty or forty examples of it since 1884. It is possible that this local prevalence may have something to do with peculiar customs. In London I have seen from time to time a few cases of watery cysts on the face, but I do not recollect a single one in which the condition was extensive until Mr. Sequeira sent to my clinical demonstrations the patient whose case I shall presently describe. I had many years ago described quite

similar cysts occurring in connection with xanthelasma. They were always restricted to the eyelids. Before proceeding to describe my own case (Mr. Sequeira's patient), it may be well to give a little summary of Dr. Robinson's observations, as he has very carefully worked the subject out. He states that all the patients he has seen have been women in middle life or older, with the single exception of a young man, aged 28, in whom the eruption was limited to the lower half of the right side of the nose. Although most of his patients were washerwomen, this was not invariable, but all had been engaged in occupations which caused much sweating. All the cases were worse in summer than in winter, and in some the eruption would even disappear in winter. The little cysts were not usually found crowded together in any considerable number, but scattered over the face. In the worst cases one hundred or even two hundred were present at the same time. They were tense, clear, shining vesicles, varying in size from a pin-head to a pea. The smaller ones presented considerable resemblance to boiled sago grains, whilst the larger ones would show a darkish blue tint most marked at the periphery. There was usually no congestion of the skin and no subjective symptoms. The contents of the vesicles consisted of a clear fluid, which never became yellow and always had an acid reaction. These contents might be absorbed and the vesicle would shrivel, leaving a yellowish spot. Dr. Robinson states that he had never been able to identify, with certainty, the existence of a sweat-duct orifice on the surface of a vesicle. By microscopical examination he demonstrated that the secreting portion of some of the sweat-glands was much dilated, and that, speaking generally, the rest of the structures of the skin were healthy. His conclusion is therefore, definitely, that the cysts result from some obstruction in the excretory tube preventing the outflow of sweat. The cause of the obstruction remains obscure. Dr. Hallopeau of Paris has described a case in which the eruption was limited to the nose, and was more severe at the menstrual period than at other times. He conjectured that the condition was much under the influence of the nervous system. In his patient also the eruption in summer was also observed. Dr. Jamieson of Edinburgh has also described a case in which the eruption was one-sided, being confined to the right side of the nose, forehead, temples and cheek. His patient was a woman, aged 45, who used to perspire freely and

easily on the right side of the body, and but seldom, and only to a slight extent, on the left side. Mr. Sequeira's patient, whose condition is illustrated in the drawing now produced, repeats almost exactly the condition described by Dr. Jamieson, and both of these, together with Dr. Hallopeau's case, give support to the opinion that the condition is influenced by the nerves supplying the part. The same view is supported by the cases which I formerly described, in which these sweat-cysts were located in connection with *xanthelasma palpebrarum*.*

Mrs. C., a sextoness, aged 64, is a florid woman, apparently in good health. She has been the mother of several children. She married at the age of 23, and was at that period liable to suffer from "fearful" headaches. She described them as sometimes so bad that she would be kept awake a whole night and could scarcely put her head on the pillow. They would frequently last for twenty-four hours, and were almost always worse on the right side. These headaches have much diminished in frequency as her age has advanced, but are still very severe when they do occur. Of late years her chief trouble has been a sort of neuralgia in the tongue, which is almost constant, and much worse on the right side. It began by entire loss of taste on both sides of the tongue, but from this she recovered after about six months. At present the irritation in the tongue is almost constant and often keeps her awake, but sometimes for a few days she is quite rid of it. She describes little blisters as forming inside her lips, probably herpes. She has a strong, rather hard pulse, and states that her mother suffered much from chalky gout and rheumatism. She herself has suffered occasionally from attacks of pain in her great toe, and her eldest daughter has had rheumatic fever seven times. Mrs. C. was brought to the Demonstrations as an interesting example of unilateral sweating, and at the time of our inspection she did freely perspire on the right side of her head and scarcely at all on her left. Mr. Sequeira had examined this curious phenomenon repeatedly, and was fully convinced of its reality. The woman had herself noticed it for many years. I do not think, however, that there was absolute absence of perspiration on the left side. When we noticed the little cysts with which her face was covered she

* See "Illustrations of Clinical Surgery," Vol. I. p. 145.

said that she thought they had been present more or less for eight or ten years. These cysts, although present on both sides more or less, were far more abundant on the right. I pricked some of them and found their contents acid. The cysts were much like sago grains, but exceedingly tense. They varied in size from pin-heads to small peas. They were very abundant on the region of the eyelids, occurring especially frequently above and below the inner canthus. They were arranged much like xanthelasma patches, with the difference that they were more abundant on the lower than on the upper lid, and on the right than on the left side. They occurred in the eyebrow, its outer two-thirds, and on the adjacent part of the forehead on both sides. There were, however, none on the upper lid itself, the most frequent location of xanthelasma. There were some on the bridge of the nose, and, with the exception of the parts named, the rest of the face was almost free. A few little globular nævi and tufts of dilated venules were seen about the cysts.

I do not think that there can be much hesitation in admitting that, in this case, the lifelong liability to hemicrania has had something to do with the final disturbance both in function and nutrition of the skin. The predominance of the sweat-cysts on the side on which the pain has been mainly accustomed to occur, and which now suffers from excessive sweating, points definitely to this conclusion. So also does the existence of tongue-and-mouth symptoms on the same side. As is usual in hemicrania, the pain was commonly, but not invariably, on one side (the right). Sometimes it was on the left. At the present time the cysts, the sweating, and the pain in the tongue are predominant on the right side, though not restricted to it. Clearly, the right fifth-nerve has been throughout more severely affected than its fellow.

The patient has never been jaundiced. She has no xanthelasma, and her headaches were never attended by sickness or any symptoms which she considered "bilious." Perhaps we may infer from this that liver disturbance has entered less than it usually does into causal relation with the habitual headaches. The latter may probably have been more neuralgic, or what is popularly known as "nervous," in character. It is impossible to ignore the importance of the topography of the cysts. They are arranged in the main like xanthelasma, but with differences. These differences are probably due to

modified causation. In both affections nervous disturbance in paroxysms is the usual antecedent, but in xanthelasma there is usually definite liver disturbance, and in the other little or none.

The patient's strong history of gout must not be forgotten. The neuralgia in her tongue is very like what I have described as occurring in many cases of gout.

CLINICAL NOTES.

A CASE OF THE IMPETIGO OF DUHRING.

BY LESLIE ROBERTS, M.D.,

Dermatologist to the Royal Infirmary, Liverpool.

UNDER this name Duhring has described a rare form of pyoderma, which he believes to be the true form of Impetigo, and, indeed, the only affection to which it is proper to apply this term. Some dermatologists, with wide experience, are unable to admit that this affection is anything more than a form of that contagious impetigo described and named by Tilbury Fox in 1862.

On November 15th, 1894, I saw the following case, in consultation with Dr. C——. The patient, aged 3 years, was the child of wealthy parents, living under the best of circumstances. The eruption was preceded by smart fever and much lassitude. The temperature quickly fell, and when the patient appeared to be convalescent a small crop of pustules was noticed on the face and neck. There was an interval, after which fresh pustules appeared on the chest. There was no further rise of temperature with the appearance of each fresh crop. When I saw the patient there were about a dozen pustules scattered widely over the whole body. One of the pustules had formed just half an hour before my arrival; it was, as Duhring describes it, distinctly and completely pustular. In this short time it had attained a size of rather more than a sixteenth of an inch. It was surrounded by a red areola; this red areola surrounded all the pustules which had not fully matured, but disappeared when maturity was reached. The older pustules were semi-globular in shape, the size of a split pea up to that of a small finger-nail, distinctly elevated, surrounded by a red zone; the colour was yellowish, with specks of white. The walls of the pustules were dense; in fact, their hardness or induration was such as I have never felt in any pustules except in those of small-pox. None of the pustules were umbilicated, but they became flatter as they matured. The walls did not rupture, and there was no free exudation, the pustule

gradually drying up into a scab. There are features in this case which seem to me to distinguish it from contagious impetigo. There was no evidence that this affection was contagious; there were two other children in the house, but neither of them have caught the disease up to this date. The lesion was pustular from its origin. The induration was second in degree only to that of small-pox pustules. There was no free exudation and irregular scabbing. The universal distribution of the lesions, with wide intervening spaces of healthy skin. On the other hand, the lesions of contagious impetigo are more superficial in their seats of development, have thinner walls, and sooner or later rupture and discharge their purulent contents. In the vast majority of cases contagious impetigo occurs in the poor and ill-fed, and those who are not well acquainted with cleanliness. On the other hand, Duhring's impetigo is usually met with in well-nourished and healthy subjects, and in those in the gentler walks of life. I regret that the circumstances of the case would not allow me to apply any experimental test, for after all it is to the laboratory that we must go for a solution of the question.

A CASE OF MYCOSIS FUNGOIDES.

BY LESLIE ROBERTS, M.D.,

Dermatologist to the Royal Infirmary, Liverpool.

THE patient was sent to me from North Wales by her medical attendant. She was 45 years of age, in comfortable circumstances, and had lost her mother and sister from phthisis. She had never been in a tropical country, and had never suffered from any serious illness before. As to the history of her present trouble, the patient can give but a vague account. Her story was practically this, that some four or five years ago a moist pruritic eruption appeared on the left arm, remained a few months and then disappeared spontaneously. The eruption continued to reappear at intervals, and was confined to one or more of the extremities. Little exact information can be obtained about the features of these early eruptions, except that they were very rebellious to treatment and disappeared sometimes spontaneously. During the last twelve months the entire cutaneous surface has become affected. The first tumour started about two or three weeks before her admission to the Royal Infirmary, and grew with astonishing rapidity. At the time of her

admission under my care (November 5, 1894), just two months before death, her general health was poor. The manifestations of the disease spread over the entire cutaneous surface, and presented a considerable amount of variation. Thus, taking the epidermis alone, it was exfoliating on the limbs in bran-like scales, on the outer side of the right foot it was excoriated, while on the hands, and especially on the palms, it was much hypertrophied. On the face the eruption was moist, constantly weeping, on the trunk and limbs dry. The skin generally had a dusky, dingy, faint red, scaly appearance and was rough to the touch. The astonishing cellular activity of the neoplasms surpassed anything I had previously conceived of. The tumours were always in one of three conditions, either they were growing, or involuting, or suppurating: there seemed to be no resting condition. The new formations on the head grew with all the rapidity of embryonic tissues. Thus a tumour over the left malar bone, which at the time of her admission was no larger than a big orange, grew in sixteen days so as to involve the whole of the right side of the face from the margin of the jaw to the upper margin of the temple. By the growth of this and the other facial tumours the eyes were closed and the nose almost smothered, so that breathing became difficult. The subjective consequences of this enormous deforming growth were pruritus of a somewhat intermittent character, a sense of great heat and flushing, of which the patient complained much, and pain, which was a later symptom, and apparently only accompanied the ulceration of the larger tumours. The tumours on the chest and limbs were numerous, but never attained a size greater than a pigeon's egg. They were all superficially seated, soft and yielding to the touch, and had a dirty reddish scaly appearance. Their contour resembled that of a round cushion pushed up in the centre into a convexity, the margin sloping gradually into the unhealthy surrounding skin. The superficiality, the absence of deep dermal induration and the cushion-like form of the tumours—*form d'un bourrelet* of the French writers—together with their remarkable embryonic restlessness, these are among the chief clinical features of mycosis fungoides. It is likewise a noteworthy and curious fact that the tumours may involute, or even ulcerate, completely without leaving a scar or scarcely a trace of their former existence. This was the case with the enormous tumours on the sides of the face, which completely disappeared before death, leaving the face emaciated but without a trace of scar tissue.

During the last two months of the patient's life, during which she was under my care, the temperature fluctuated in a manner very similar to that of chronic pulmonary phthisis. There was the evening rise with morning fall, with periods of exacerbation of temperature, followed by intervals of depression when the temperature was normal or subnormal. The patient had a moist cough, and complained of pain in the right side.

Another remarkable feature about the case—as indeed about every case of mycosis fungoides—is that no drug seems to have any influence over its career, in which respect it presents a further analogy with the embryonic processes. Carbolic lotion (1 in 20) was injected into the largest of the tumours to the extent of one drachm. It produced skinking and sloughing in the area injected, but as it seemed rather to aggravate the offensive discharge, which continually oozed from the facial tumours, the remedy was soon abandoned. Pyrogallol was applied in ointment-form to some of the smaller tumours, but with no benefit. An amelioration of the general and diffused condition of the skin of the trunk and limbs was brought about by the change in the patient's mode of living. Just previous to her entry into hospital she had been fully occupied day and night with nursing her bedridden father, who was afflicted with paraplegia with incontinence of urine and fæces. This condition of unrest, with its extraordinary demand on nerve and strength, no doubt aggravated the disease; for a few days rest in bed with daily warm mild sulphur baths did, most appreciably, ameliorate the *eczematoid* symptoms. Towards the end pain became the most distressing symptom. In order to relieve this and the other symptoms it was found necessary to administer half a grain of morphia subcutaneously thrice in the twenty-four hours, and even this produced only fitful sleep and numbing of the pain. During the last four or five days before death there was rapid emaciation of the whole body, including the neoplasms. The large tumour on the face completely disappeared. The skin became harsh, dry, and contracted, and of a dirty greyish colour. In the autopsy an old tubercular cavity, but with tubercle bacilli still present, was found in the base of the left lung. There were no secondary growths in any of the internal organs. For the bacteriological and histological reports the reader is referred to the author's complete report of the case which will appear in a forthcoming number of the *Lancet*.

CRITICAL DIGEST.

THE DISAPPEARANCE AND REGENERATION OF THE ELASTIC TISSUE OF THE SKIN UNDER VARIOUS PATHOLOGICAL CONDITIONS.*

THIS is one of the "Dermatologische Studien," edited by Dr. Unna, and consists of two excellent monographs describing the degeneration and regeneration of the elastic tissue of the skin. To the authors of these essays was adjudged the Unna prize for 1892-93.

The first essay, by Kurt Passarge, of Königsberg, deals with the subject mainly from the point of view of its histological aspects in various morbid conditions. In an introductory section the author describes the method preferred by him in the study of elastic tissue, and selects Manchot's Fuchsin method, Taenzer's Orcein staining, and the use of Unna's preparation of acid Fuchsin as yielding instructive specimens. As a method of comparison with the above-mentioned specimens, Balzer's method, by the use of potash solution on eosin-stained preparations, is mentioned as of service.

1. *Degeneration.*—A number of morbid processes affecting the skin and their influence on the elastic tissue are considered in detail.

Passing over the lesions of scarlet fever and of œdema as having little influence on the elastic structure, the first important condition considered is that of Inflammation. Taking as his point of departure the changes described by Manchot in the elastic tissues of arteries undergoing aneurysmal dilatation, in which the fibres become broken up by transverse fissures into fragments retaining their mutual position, and also statements concerning the degrees in which the power of retaining stains is conserved by these fibres, which tend to prove that in certain cases the fibres totally vanish, the author states that he is able only in part to corroborate these observations.

From the examination of several abscesses involving the skin, the author is led to the conclusions that, although changes appear even

* Hamburg and Leipzig, Leopold Voss, 1894.

in slight inflammatory infiltrations, these are only of the nature of separation of the elastic fibres by the infiltrating exudation, in higher degrees of inflammation a degeneration of the fibres takes place, but the fragments are held in mutual relationship by a tissue incapable of staining, so that the fibres appear now to have a transverse striation. Even in severe purulent degeneration of the connective tissues the elastic fibres remain capable of being readily recognized for a long period, and their destruction after prolonged inflammation is but slow and incomplete.

In Gangrene a sharp distinction is drawn between the dry form and the moist. In the case of the former variety the elastic bundles remain quite unaltered, whereas in the latter a complete destruction may befall the fibres. In the case of moist gangrene an early diminution is observed both in the number and in the length of the larger fibres. Moreover these altered fibres are no longer capable of being stained equally throughout, but may be observed in the form of small blocks or granules connected by semi-translucent material incapable of taking stains. By the use of the eosin-potash method, already mentioned, it is striking, however, to find that in such an area, in which the larger fibres are so obviously undergoing degeneration, a fine network of extremely delicate elastic fibres can still be made evident. But this result can only be obtained if the destructive lesion has lasted for a short period; very soon complete destruction of all the fibrils occurs, and none are brought into view, even on minute examination, after treatment by the method alluded to.

Among the Granulation processes the author's attention has been mainly directed to lupus. In this connection he alludes to the interesting observation by Sudakewitsch, that elastic fibres may be observed in the interior of the giant-cells, where they disappear with the gradual loss of their affinity for staining materials. At any rate, the author is able to confirm the observations of others that, although in the peripheral portions of a lupus nodule, or of tubercular areas elsewhere, elastic fibres may be readily observed, towards the central portions they disappear, and this disappearance is due to the degenerative changes which they undergo. Similar changes occur in other specific granulation tissues, such as that of leprosy, syphilis, etc.

The subject next dealt with is the vexed question of the alterations in the skin in the "*Striæ Gravidarum*." After quoting the state-

ments of observers from Hebra down to the recent observations of the French school, our author inclines to the more recent descriptions. He describes the presence of elastic fibrils in the large macroscopic striæ, but admits their extreme delicacy and sparse distribution. The larger fibres are torn through by the stretching of the skin just as are the other connective-tissue bundles. They may be seen at the margins of the striæ in large numbers rolled up by their own elasticity. Very few of them are continued across to the opposite side, and these only as attenuated processes. The question now arises, "are the fine elastic fibrils of the striæ itself the relics of the teased out and torn original fibres, or are they not the result of regeneration of elastic tissue in the quiescent striæ." The author does not commit himself to the opinion that these fine elastic fibres are of new growth, but he adduces observations in its favour, and evidently considers that the hypothesis is tenable, and deserves further consideration and support.

The behaviour of the elastic tissues in their relation to true tumours is interesting, as showing the various results of different methods of preparation. By Manchot's fuchsin method it appears that the elastic fibres undergo complete destruction at the margin of tumours affecting the connective tissue of the skin; by the use of orcein and eosin-potash preparations numerous fine elastic bundles appear in the peripheral portions of these tumours, becoming more and more degenerated as the central portion of the tumour is approached, while in the centre of such growths as sarcomata and fibromata their structure is quite devoid even of the remnants of elastic tissue. In cases of scleroderma and elephantiasis, on the other hand, there seems to be an increase in the elastic bundles, just as there is also a hyperplasia of the ordinary connective tissue, an opinion long upheld by Crocker, Payne and others in this country.

The author now enters on a criticism and description of the views held as to degeneration of the elastic tissue in old age. The description quoted at length is that of Schmidt, who mentions two methods of degeneration as characteristic of advancing age:—

1. A gradual swelling and disappearance of the elastic tissues, so that, at first losing their characteristic capacity of retaining certain stains, they at length become swollen and melt away, being replaced by a homogeneous semi-translucent material.

2. A granular degeneration, the fibres becoming broken up and replaced by rows of granules, which in their turn also become glassy in appearance.

These views in certain points the author is able to confirm as a result of his own observations.

The writer first deals with the thinning and atrophy of the skin, so evident in old age, as bringing about an apparent approximation of the elastic fibres owing to the degeneration of the intervening bundles of connective tissue, and quotes the interesting experiment, that a piece of skin from a young person of twenty years of age, if treated artificially, so as to destroy the ordinary connective tissue bundles, may in twenty-four hours be brought to present the appearances of skin removed from an individual of forty years, so far as elastic fibres are concerned.

The situations in which atrophy of the elastic tissues first commences are dealt with, and, according to our author, these are :—

1. In the sub-epithelial elastic network of Unna.

2. In those fibres which surround the hair-bulbs, including the fibrils made use of by the hair-muscles for their point of attachment.

As to the method in which these elastic fibres disappear, the author quite agrees with what Schmidt has described as his first method—that there is a gradual swelling of the fibres, in which process there may occur longitudinal or transverse striation of the elastic elements.

The second method described by Schmidt, that there is a granular degeneration of the elastic fibres which precedes the oedematous condition, our author is quite unable to support. The granules which are apparent in the skin under such conditions rarely consist of extremely fine elastic fibres.

In concluding this portion of the monograph the author states his opinion that the elastic fibres of the skin consist of a single homogeneous material, in contradistinction to certain authors, *e.g.*, Schwæbe, Ewald, and Mall, etc., who have described two different sorts of substances as forming the elastic tissues.

II. *Regeneration.*—In considering this part of his subject the author alludes to the long-supported idea that elastic fibres when once destroyed could not be replaced, and speaks of the persistence with which this view was urged. He mentions Sudakewitsch's early experiment on the Ligamentum Nuchæ of dogs, by which the power

of elastic tissues to become regenerated was proved, and states that in face of this proof Kölliker's text-book, appearing ten years later, makes no mention of the facts.

The regeneration of elastic tissue in operation scars is first treated. Our author is able to show the presence of fine elastic fibres in scars of six weeks' duration onwards. He arrives at the conclusion that these fine fibrils are of new formation, and are not derived directly from the large fibrils of the surrounding skin, which can be seen sharply cut off at the margins. It is in the superficial portion of the scar that the new formation is first noticed, but in process of time the scar is not to be distinguished histologically from the surrounding tissues.

There appears to be little of special interest in the changes brought about in elastic tissues during the healing of ulcers beyond the tenuity of the newly-formed fibrils.

In reference to the manner in which the new elastic fibres are formed, the author gives a historical history of the observations and opinions which have been advanced on this subject.

It appears that at one time or other it has been stated by the most distinguished observers that the elastic fibres are formed:—

I. From connective tissue cells. (a.) By modification of the cell processes. (b.) By some inherent property of the cells by which this elastic material is secreted. (c.) By transformation of the cell protoplasm. (d.) By growth from their nuclei.

II. By differentiation of the ground-substance of the connective tissue.

As so many hypotheses have been advanced, a decisive opinion is difficult to pronounce, although the weight of evidence seems to be, according to Passarge, on the side of those who declare that no connection of the elastic fibres with cell processes has been proved.

In conclusion, the author remarks on the noteworthy fact that the elastic fibres found in scars produced in his experiments retain for long their young appearance, and that the visual and chemical characteristics of the fully developed fibres is only gradually assumed.

This paper is illustrated by two coloured plates of the appearances described in the text.

JAMES GALLOWAY.

(*To be continued.*)

SOCIETY INTELLIGENCE.

DERMATOLOGICAL SOCIETY OF LONDON.

At an Ordinary Meeting of the Society, held on Wednesday, April 10th,

Dr. RADCLIFFE CROCKER presented the case of a lady, æt. 36, with *Leprosy of the tuberculated variety*. The patient was born and bred in one of the colonies, in which, however, the disease only exists sporadically, and from importation. There was reason to believe that it might have been contracted from another case, though the evidence was purely inferential. The disease was of eight years' standing, but had developed slowly, and when shown there was only moderate infiltration of the face, which was of a mahogany tint. The ears were not affected. The hands were brownish and moderately infiltrated. No sensory disturbance was now noticeable, but at one time there had been some pain down the ulnar nerve and slight anæsthesia in its course, but this has passed off. Numerous patches of discolouration were observed on the body, but only a very few nodules.

Dr. COLCOTT FOX presented (1) a man, aged 35 (F. G.), with an *extraordinarily copious papular Syphilide*. The patient had noticed a chancre four to six weeks previously, and its remains were recognizable about the frenum, which was partially destroyed. The eruption was of eight to nine days' duration, it was stated. There was general adenitis and congestion of the fauces. The face, neck, trunk, and limbs were so thickly studded with eruption that the latter was almost confluent. The face was covered with small, round papules, the size of ordinary shot, set in a general congestion of the tissues, so that at first sight an early stage of variola was counterfeited. On the trunk and limbs the eruption was partly macular and partly papular. Every follicle appeared to be the seat of a minute papule, and in addition there were some rather larger rounded papules, and a few the size of a split pea. The colour was very characteristic. The

eruption stopped short at the wrists, but extended on to the dorsum of the feet.

Dr. COLCOTT Fox exhibited (2), in contrast to the above case, a man (Arthur C.), aged 22, with a *relapsing pustular Syphilide* of the posterior aspect of the trunk. There was a history of syphilis two years previously, and on the posterior wall of the pharynx was a gummatous ulcer. The pustules were acneiform and ecthymaform, and the peculiar feature was the rosy-red colour of the base of the pustules, quite unlike the ordinary syphilide. The patient had not taken any medicine, and it did not seem probable that the eruption was primarily due to pus cocci, though the fresh rosy colour of the lesions might own such a cause.

Dr. COLCOTT Fox also brought forward (3) several examples of *follicular eruptions* for comparison. The first was a case of the *Lichen spinulosus of Devergie* (*Lichen pilaris* of Crocker). The case was similar to the one the exhibitor showed at the last meeting of the Society. The eruption consisted of aggregations of erected and plugged follicles, which had been present about six months. There was a little group of six lesions on the forehead, two symmetrical elongated patches on the outside of each elbow region, a rounded patch on the left buttock, and a symmetrical aggregation on the outside of each calf. The papules composing these aggregations were minute, follicular, reddened, rounded, with a central plug which was either comedo-like or spinous. It appeared as if the lesion began by the formation of a tiny plug, and to this succeeded some surrounding congestion. The hairs were dwarfed. The boy, aged 7 years, used to suffer from a bad throat and swollen neck glands, but this has passed off. He had a somewhat delicate appearance and was not very well nourished.

It is interesting to note that Brocq, in his important paper, "Notes pour servir à l'histoire de la kératose pileuse," remarks that Crocker distinguishes "un lichen pilaris maladie à marche assez aiguë et rapide dont il est difficile de préciser la nature, mais qui n'est sûrement pas la dermatose que nous étudions."

A second case (4), was that of a girl, aged 4, who presented what the exhibitor believed to be a good example of true Ichthyosis, specially picking out the follicles (*I. follicularis*). All the follicles of the body were projected, but, although the skin felt rasp-like, there was no

spine and no noticeable congestion. The skin between the lesions was not obviously xerodermic, but the palms were distinctly dry, and like those in mild Ichthyosis. The condition had existed, it was said, from birth. A sister was in a very similar state.

A third case (5), a boy, aged 13, was an example of the *Keratosis pilaris of Brocq* (Xérodermie pilaire of Besnier). Here the papules were very similar, but many were distinctly congested. There were no spines. There was no aggregation into patches as in the Lichen spinulosus of Devergie, and, on the other hand, the lesions were not so generalized as in Ichthyosis. The backs of the arms, buttocks, and thighs were specially involved, but a considerable number of lesions existed also on the trunk.

The fourth case (6), a boy, aged 8½ years, was an example of *Lichen scrofulosorum*. The boy had a corneal ulcer, and slightly enlarged glands down the sterno-mastoid muscles. There were signs of bronchial catarrh; the temperature on two afternoons was 101·2° F. and 99·4° F. respectively. The boy collapsed every day, going to bed after the mid-day meal, and tuberculosis was suspected. The follicular eruption occupied all the trunk and lower part of the neck and the thighs. The lesions were distinctly reddened, but did not itch. The case was somewhat unusual in that the eruption was so copious that only slight indications of aggregation in patches was observable. Very frequently Lichen scrofulosorum is grouped like the Lichen spinulosus of Devergie. There were no spines, though little adherent scales simulated spines. Dr. Fox illustrated this eruption by the drawing of another very similar case, in which large glands in the neck were removed and proved to be tuberculous.

Dr. JAMES GALLOWAY showed (1) the case of a boy, of 8 years of age, suffering from a *follicular eruption*, situated very profusely on the arms, legs, and buttocks, but little evident though present on the trunk. The eruption consisted of bright red inflammatory papules, varying in size from a millet-seed to the size of a sixpenny-piece, when they were evidently composed of an agglomeration of smaller papules. The papules were situated round the sweat, or hair-follicles, the centre of each in the earlier stages of the eruption being marked by the orifice of a duct or a small hair. In some of the spots there appeared to be present a droplet of fluid, either sebaceous or puru-

lent in its character. On dying away the lesions left flat-topped papules, which had given rise to the diagnosis of *Lichen planus* by some who had seen the patient. The lesions had lasted for five months, and had caused little or no inconvenience to the child; there was practically no irritation and no marks of scratching. Dr. Galloway requested a diagnosis of the condition, his own opinion inclining to its being a somewhat anomalous form of "*Lichen urticatus*," although its distribution and the absence of distinct urticarial lesions militated against that view; or possibly being due to infection by one of the pus-forming cocci.

Dr. RADCLIFFE CROCKER suggested the probability of the condition being a drug eruption, possibly due to Bromine. Dr. Colcott Fox was inclined to consider the condition as one of *Acne scrofulosa* ("cachecticorum"). Dr. Galloway remarked that he thought that no drug had been administered during the last three months at all likely to give rise to this condition (this opinion is confirmed by the perusal of the notes of the case at the Great Northern Hospital); and although the parents had been in almost destitute circumstances last year, and no doubt the child had been badly fed then, they were now in better circumstances, and the child was well cared for and was in excellent health.

This patient had been kindly sent to Dr. Galloway by his colleague Dr. Syers.

Dr. GALLOWAY also presented (2) the case of a young woman, aged 22, who had for several years suffered from a condition of *chronic œdema of the eyelids*. There was now no local or general condition to give rise to this state. A history, however, was given of an attack of facial erysipelas eight years ago. This case, it was generally agreed, was one of chronic œdema, due to lymphatic obstruction resulting from erysipelas.

Dr. GALLOWAY also showed (8) a case of *chronic exfoliating Inflammation affecting the lower lip*. This patient, a young man of 23 years of age, had been sent to Charing Cross Hospital from the Dental Hospital, Leicester Square, by Mr. J. F. Colyer, on account of the difficulty of doing anything for the teeth while the lip was in this condition. This case resembled very strikingly the woman brought forward at the last meeting of the Society by Dr. Galloway. The disease had lasted for five months, and was characterized by the

constant formation over the red part of the lower lip of a muco-epithelial crust which grew to about $\frac{1}{8}$ -inch in thickness, cracked, and in about eight or ten days peeled off. The lip did not ooze, nor was its surface moist at any time. A considerable degree of swelling was present, so that the lower lip protruded just as in the previous case shown. The patient was in good health, and showed none of the neurotic peculiarities so evident in the case of the woman. The present case was not nearly so severe as the former, and had already much improved under the influence of emollient preparations.

Dr. Galloway mentioned that his attention had been drawn by Mr. Hutchinson to four similar cases described by him.*

These cases are undoubtedly of the same character, the histories given bearing a striking similarity to the case of Miss W., presented at the last meeting of the Society. The present case is of a much milder character, and it is hoped may prove less resistive to treatment than the previous cases recorded.

Mr. MALCOLM MORRIS presented the case of a young lady who is suffering from extremely marked permanent distention of blood-vessels localized to the anterior half of each foot and on the hands.

Dr. PERRY showed the following cases:—(1.) *Secondary Syphilide*. Margaret M., æt. 12, was brought to Guy's Hospital by her mother with an eruption upon the trunk and limbs, the face and neck being unaffected, and the body being more severely implicated than the extremities. The eruption had been present for several weeks, and was of a very polymorphic character, in parts consisting of flattish papules with circular grouping, in others of small red raised areas with yellowish crusts or scales somewhat resembling ill-defined patches of psoriasis, in others of scattered papules without definite arrangement. There was no irritation, and the child seemed to be in good health. The knees, however, were greatly enlarged, the articular cavities being distended with fluid (hydrops articuli). This affection had been present for three years, and the child had been treated for it as an in-patient in St. Bartholomew's Hospital. The exact nature of the synovial effusion was not determined. It was thought by the majority of those present and by the exhibitor himself that the

* *Archives of Surgery*, Vol. II, No. 8, Oct., 1890.

eruption was a secondary syphilide, though no primary chancre was discovered. It appears, however, that the mother contracted syphilis from the father seventeen months ago, and that she has a syphilitic baby, which is nursed by her daughter, and it seems possible that the disease was contracted by the child either from her mother, or more probably from the baby. There was no evidence of sore-throat, nor of glandular enlargement, and one member was disposed to diagnose the eruption as an unusual form of scrofulide, the articular condition on this hypothesis being regarded as tuberculous.

(2.) *Lichen scrofulosus: enlarged Caseous Glands.* James H., *æt.* 7 years, a thin, pale boy, presented himself with enlarged caseous glands beneath the angle of each jaw, and in the right groin. The cervical enlargement had been noticed for three months, and the inguinal glands had been observed for a fortnight, and they seemed to be rapidly increasing in size. A year ago the child was a patient in Guy's Hospital under the care of Mr. Colley, when a growth, probably tuberculous in character (*lupus verrucosus*), was removed from the back of the right tendo Achillis a little above the heel. This growth was ascribed by the father to chafing occasioned by an ill-fitting boot. On the front of the trunk an eruption had been seen for the last five weeks, which when first observed by the exhibitor closely resembled the patches of pityriasis maculata. Three weeks later, when shown to the Society, the patient had an efflorescence of brownish-red papules covering almost the whole of the front of the body below the line of the nipples, extending to the groins and about two inches down the front of the thighs. On the back the parts affected lay between the angles of the scapulæ and the crests of the ilia. There was little appearance of grouping, though, when these were first seen, this arrangement was very evident. The papules were small, flattened on the tops, free from scales, and caused no irritation. A fortnight later, under the administration of cod-liver oil internally, and boric acid ointment as a local application, the skin had almost entirely recovered its normal appearance, few traces of the eruption being discoverable.

(8.) *Chronic Urticaria.* Mabel H., *æt.* 15, a tall well-nourished girl, presented upon the extensor surface of her thighs, and in smaller numbers upon her trunk, an eruption consisting of black-topped scabbed papules. When a child of seven years old she was brought

to Guy's suffering from well-marked urticaria papulosa (lichen urticatus), many of the papules being distinctly vesicular. Since that time she has never been completely free from the disease, which is always worse during the summer months. In the early years the development of wheals was very abundant, but latterly this phenomenon has not been so conspicuous. No cause for the disease has been discovered, the patient appearing to be in perfect health; and the case is regarded by the exhibitor as a chronic urticaria rather than as an example of Hebra's prurigo, unless indeed Hebra was mistaken in supposing the primary lesion of that disease to be a white sub-epidermic papule. Here the primary lesion is undoubtedly urticarial in character.

(4.) *Hyperidrosis: Pompholyx.* Mary A. P., æt. 7½ years, has for the last three months been affected with a bullous eruption, limited to her hands and feet. Last Christmas she had broken chilblains on these parts, and at the same time chicken-pox. For the chilblains the extremities were swathed in some kind of ointment, and the present eruption developed in the course of the treatment. The patient is a delicate child, who has had several attacks of bronchitis; she has brown hair and a clear skin, is thin, and of quick intelligence. Her mother states that the child perspires very readily in all parts of the body, and when first seen by the exhibitor her hands were noticed to have a white sodden look, where the skin remained intact, and both hands and feet were bathed in a profuse sweat.

On the palms of the hands there were large areas denuded of epidermis and exposing a red tender surface, soft, and free from exudation. There were also several bullæ, varying in size from a split pea to three-quarters of an inch in diameter. The fluid contained in the bullæ was clear, and there was entire absence of pustulation. There were no lesions to be found on the sides of the fingers and none on the backs of the hands; the nails were well formed, and free from pitting. The eruption is attended with little or no irritation, and in spite of treatment has remained practically unaltered for three months.

On the feet the condition is similar, except that there are no large bullæ, and most of the epidermis has been removed. There are, however, numerous "sago-grain" vesicles on the under surface of

the big toes, and there are vesicles between and on the ends of the other toes. The lesions also affect the outer border of each foot, the dorsum being quite free. The feet were damp with perspiration, and tender, so that walking occasioned some discomfort.

The case appears to be worthy of record from the early age at which the attack occurred, namely, a little over seven years. Dr. Radcliffe Crocker observes that he has never seen a case in a patient under twelve years old, and Mr. Hutchinson that he has never seen the disease below puberty.

Dr. SAMUEL WEST showed (1) an important case of *Pityriasis rubra pilaris*, full details of which will appear in a future number of this Journal.

Dr. SAMUEL WEST showed (2) a case of *Lupus erythematosus*. Mrs. W., aged 49, a washerwoman, had had a red rash on her fore-arms for about twelve months. It extended from the wrists to the elbows, chiefly upon the extensor surface, but reached round the sides to the flexor surface also. There was nothing special to note of the rash here, nor of the two symmetrical patches on the calves of both legs, about the size of the palm of the hand. The patient was exhibited because of the eruption on the face. This extended from the bridge of the nose to the ears on both sides, involving the lip and sides and tip of the nose, but not the middle part between the tip and the bridge. This had appeared first at the end of January this year, so that it had reached the present extent in about six to eight weeks. Upon the lobe and inside of the ear it was fairly characteristic, and covered with slight scales, but upon the face it was of the telangiectatic form without any scaling, some of the vessels being as large and distinct as they are in *Acne rosacea*. The patient had been under observation for a month, and during that time the redness had disappeared to a great extent on the middle of the cheeks, and the varicose vessels were not as striking as when first seen. The patches on the legs and arms had been regularly spreading since they first appeared twelve months ago, and had not changed, but there had never been more than very slight swelling. They were always worse in cold weather. The patient was not in very good health—suffering from dyspepsia and feeling weak.

THE DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.

At the meeting of this Society held on Thursday, April 11th (Dr. PYE SMITH, F.R.S., President, in the chair),

Mr. GEORGE PERNET read notes of the bacteriology of the case of *Acute Fatal Pemphigus* recently communicated to the Society (*vide The Brit. Journ. of Dermatology*, April 1895, p. 120), which had been investigated by Dr. W. BULLOCK, as follows :—

Röser, Vidal, and Colrat demonstrated the inoculability and auto-inoculability of the fluid of pemphigus vesicles. Gibier (1881) found in the contents of vesicles, and also in the urine of pemphigus patients, short chains of cocci. Sahli (1885), in broncho-pneumonia following pemphigus, also found small cocci.

The most careful research was made in a typical case of acute pemphigus occurring in a boy 13 years of age, by Demme (1886), who found micro-organisms in the bullæ and in the blood. These organisms presented great similarity to Neisser's gonococci, but were bigger. They showed a tendency to grow only at incubation temperature. Demme described and figured characteristic growth on agar, but inoculation into the subcutaneous tissue in guinea-pigs, rabbits, cats, dogs, and pigeons, was without result. Inoculation into the lung direct, however, gave positive results in eight guinea-pigs; progressive emaciation, loss of strength, and disseminated broncho-pneumonia patches. Diplococci were found in the patches, and also in the blood, growing characteristically.

Dähnhardt, in pemphigus chronicus, found organisms identical with Demme's.

The most important confirmation of Demme's results has been made by Bleibtreu in a typical case of acute pemphigus of twenty-seven days' duration. Claessen, who made the bacteriological examination, found a coccus identical with Demme's.

As to Mr. Pernet's case, now under consideration, fluid from a pemphigus bulla was inoculated on sloping agar.* In twenty-four hours whitish colonies developed—all uniform. Microscopic examination showed that the colonies were composed of diplococci having

* About twenty-four hours after death, while *rigor mortis* was still marked.—*British Journal of Dermatology*, *loc. cit.*, p. 123.

very close resemblance to the gonorrhœa coccus, but larger. They were, however, distinguished at once by the fact that they retained their stain by Gram's process, while the gonococcus of Neisser is decolourized. From the original tubes cultures were made on different media. On *bouillon*, at incubation temperature, growth takes place rapidly, and in the course of twenty-four hours *bouillon* becomes cloudy. Later on, the cloudiness sinks to the bottom of the tube, but a pellicle may be found on the surface.—*Agar-plates* (37·5°): In thirty-six to forty-eight hours small circular or oval white colonies appear. They are slightly raised above the centre. These increase in size for a time, but in about six to eight days they increase by further throwing out of circular or club-shaped prominences, *exactly as described by Demme*, and their contour becomes irregular (rosette-like appearance). The surface after ten days is irregular, and the colour yellowish.—*Agar-thrust cultures* gave rounded colonies at first along the whole track of inoculation. Growth also occurs in the form of a flat expansion on the surface.—*Sloping agar surface*. Same appearance as plates, sometimes moist, glistening whitish layer. The individual cocci are concave on the opposed surfaces. They are non-motile.—*Staining reactions*. Stain well with all watery aniline solutions, especially Loeffler's blue. *Stain well with Gram's method*.—*Gelatine Plates*. Growth extremely slow and the colonies ill-defined.—*On glycerinized potatoes*: white, moist, glistening layer, which after a few days seems to grow. In *anaërobic* conditions (Vignal's tubes) the organism forms small round or lenticular colonies. No production of gas.—*Examination by hanging drop*: Cocci in pairs, *i.e.*, diplococci. Seldom chains. The chains when occurring are short.

The interesting micro-organism is still under observation.

Dr. BULLOCH made some observations corroborating the description given by Mr. Pernet, and adding further details as to the methods of his investigations.

Mr. BUXTON SHILLITON had lately seen a case of pemphigus following a lesion on the finger. The symptoms had existed over several years.

Dr. P. S. ABRAHAM showed (1) a case of *Pityriasis rubra pilaris* of Devergie.

A boy, H. D., æt. 6, came to the West London Hospital last month in the following condition :—The palms of the hands and soles of the feet inflamed and of a bright red colour, and covered with large masses of desquamating epithelium ; redness and scaliness of the elbows and knees, the same condition of the eyelids, nostrils and mouth ; a branny desquamation of the scalp and face, and a xerodermic condition of the skin of the limbs and other parts of the body. On the nape of the neck and down the spine the follicles were indefinite areas enlarged from an apparent hypertrophic condition of the epidermis. He complained of no sensation of itching, and only of pain of the hands and feet when using them, or when they were washed.

The mother stated that the affection had commenced about a week before coming to the hospital, and that he had had a precisely similar attack two years ago, a few months after being ill with scarlatina.

The appearance of the palms and soles, knees and elbows, reminded one of certain forms of psoriasis, or perhaps of Dr. Brooke's Erythema keratodes ; the face had a look of dry eczema, and the scalp of dry seborrhœa. The combination of lesions, however, the history of the case, and especially the follicular affection on the neck and back, seemed to place the case at once as one of Devergie's Pityriasis rubra pilaris.

The patient had undergone marked improvement during the last three and a half weeks—since first seen—under the use of tar-baths and inunctions, and cod-liver oil internally.

Dr. CAVAFY said that the case presented many similarities to one he had shown at the Dermatological Society of London. The conditions of the palms and soles were very similar. There were differences in the distribution of the erythema and in the state of the scalp. On the whole, he agreed with Dr. Abraham's diagnosis. Lichen acuminatus and Pityriasis rubra pilaris were generally thought to be identical in this country. His own case had improved under simple applications of olive oil ; and, indeed, these cases generally seemed to get well spontaneously. Replying to a question on treatment, Dr. Abraham stated that he had treated the present case with a mild tar ointment and small doses of cod-liver oil.

(2) *Bromide eruption* in an infant.

A male infant, J. P., æt. 10 months, came to the West London Hospital on April 8, with an extensive crusted, irregular placed erup-

tion on the head, face, arms and legs. Some of the lesions—the newer ones—are discrete and pustular, the others larger and irregular and apparently formed by confluence. The latter have a raised red base.

The mother states that the spots first came on the body about ten weeks ago, but that they have since disappeared from this position. She says that the child had at the time a bad cough and a fit, and that a week later the eruption, supposed to be chicken-pox, broke out all over the body.

Dr. BENNETT, of Ealing, who has been kind enough to write to the exhibitor about the case, informed him that he ordered at first for the child a mixture consisting of 5 grains of bromide of potassium, to be taken occasionally. He stated also that "the rash, when it first appeared, consisted of a few small vesicles resembling those of chicken-pox."

Apart from the history, the appearance and distribution of the eruption were, to the exhibitor's mind, sufficiently indicative of a bromide eruption.

Dr. STOWERS regarded the case as being undoubtedly one of bromide eruption. He remarked that most cases followed small doses of bromide, often administered.

(3) A mother and two children, the subjects of *Congenital Alopecia*.

Mrs. P., æt. 33, has complete absence of hair from the eyebrows, eyelids, arms, legs and body, but a scanty supply on the scalp, pubes and in the axillæ.

She states that she was born with a little "fluff" on the head, but that it very soon came off, and that she remained quite bald and without hair anywhere until about 18 years of age, when it came on the head by degrees and on the axillæ and pubes.

She has been married nine years, and has had only two children (girls) now exhibited.

H. P., æt. 5, was born with a very little white down on the head, which fell off when about three months old, and she has been ever since in the nearly complete condition of alopecia now seen.

E. P., æt. 15 months, apparently completely without hair. Was born with little real black hair, which also fell off when three months old.

There is no history of anything of the kind in the family, nor have

any of its members ever been aware of coming into contact with ringworm.

In reply to a query put to him by Mr. Sheild as to prognosis, Dr. ABRAHAM replied: In answer to the question of prognosis in these cases of congenital alopecia, the mother's case shows that a partial growth of the hair may, at any rate, be looked for, although, as a rule, I believe, complete alopecia is generally considered hopeless as regards treatment. I may mention some observations now being carried out in this connection. Some of my alopecia patients are now being treated by the internal administration of thyroid gland, and I am bound to say that, even in an old and complete case of some twenty-three years' duration, after a persistent treatment of about ten months hair has begun to sprout on the eyebrows and body as well as on the scalp. I may allude also to the interesting experiments of Dr. George Stoker with oxygen gas. In one of his cases a copious growth of hair took place on a man's forearm and hand, over the surface, indeed, which had been submitted to the constant action of a stream of oxygen. This case led to the trial of the gas for alopecia, and in a child sent by me to Dr. Stoker a distinct effect was produced after a few weeks' application. The whole matter, of course, is in an experimental stage, but it is my intention to make further attempts with oxygen in other cases.

Mr. SHILLITON gave an account of a remarkable case of tertiary syphilis where the symptoms relapsed after treatment.

CURRENT LITERATURE.

ON ACNE NECROTICA. W. DUBREUILH. (*Archives Cliniques de Bordeaux*, August, 1894.)

THE chief interest in this paper lies in the description of microscopical sections of the excised lesions. Dubreuilh has obtained specimens of lesions corresponding clinically to the various forms described by previous authors and has been able to demonstrate the identity of the diseases described under the names of *acné pilaire* (Bazin, 1860); *acne frontalis seu varioliformis* (Hebra); *lupoid or atrophic acne* (D. Bulkley); *acne necrotica* (Boeck). They differ only in the extent and depth of the lesions.*

Dubreuilh's observations are based upon twenty-five cases, from four of which portions were excised for examination.

Eight of these cases are described *in extenso*.

He gives a complete account of the symptoms, etiology and pathology of the disease and discusses the diagnosis and treatment.

In its ordinary form the *primary lesions* consist of papules of the size of a lentil or a little larger. They appear to be of this volume from the first, and do not subsequently increase in size. They are moderately raised, of bright rose-colour and firm to the touch, with margins a little diffuse. The summit of the papule is generally pierced by a hair. After a few days, or even hours, the apex presents a circular yellowish waxy-looking spot, which consists of a soft adherent crust still covered with epidermis. *When completely developed* the papule is of a red colour, measures 5 to 6 mm. in diameter, and its summit is occupied by a crust 2 to 4 mm. wide, circular, yellow or brownish in colour, adherent, slightly depressed below the surrounding parts, and traversed at its centre by a hair or by several hairs with one central. The crust is soft and greasy to touch, like wax; on removing it there is left a punched-out cavity with oozing base, or containing a trace of thick pus. The crust appears not to increase in size after its first formation. Sometimes violet hæmorrhagic points are observed in the crusts (Boeck). At the end of one to three weeks the crust becomes drier and harder, more depressed and less firmly adherent. The papule itself becomes brown or violet in colour, and less prominent, till finally the infiltration disappears, leaving simply a brown or violaceous areola round the crust. The crust at last falls, leaving a cicatrix below, which corresponds with it in form and size, is fine and supple, and depressed like the scar of variola. At first pigmented, it becomes white in course of time. An important characteristic is that it is not bald, but remains always pierced by one or more hairs.

The cicatrices may be extremely numerous, so that not a cubic centimeter of healthy skin may remain on the face.

* The only previously published examinations of excised portions are those of Touton, 1892; Fordyce, 1894; and of the crusts by Boeck, 1889.

The period of evolution varies from one week to two months. The appearance of the eruptive elements is always successive, so that one always finds lesions of various ages, though the rate of formation of lesions may vary at different times, so that during a long period there may be outbreaks of more or less intensity, separated by intervals of comparative inactivity.

The distribution of the eruption.—Its seat of predilection is the brow; often it forms a band occupying the whole anterior border of the scalp, and especially the middle line, the temples and the triangle of hair in front of the ear. Other favourite situations are behind the ears and at the sides of the neck. Any part of the face may be attacked, notably the upper and lateral portions of the forehead. Less commonly the eruption extends to the trunk, the upper part of the back, the chest, and very rarely the limbs.

The more typical and largest lesions are found on the trunk, the less typical on the scalp, and the most superficial on the forehead.

Besides the ordinary type there are modifications dependent on the seat, extent, or depth of the lesions, or on secondary complications which alter their aspect. There are cases in which the lesions are comparatively small and superficial, and may pass away with little or no scarring, others in which larger lesions exist, so that the scar may be even large enough to admit the tip of the finger. These latter usually occur on the trunk. Again, an impetiginous element may be added, leading to suppuration and ulceration of the lesions.

The subjective symptoms are usually insignificant. There may be a little itching.

PATHOLOGICAL ANATOMY.

The crust.—There is little to add to Boeck's microscopical description of these. The larger crusts are made up chiefly of a network of elastic tissue, corresponding to the reticular layer of the skin, and to the papillary layer.

Mixed up with these are altered connective tissue fibres, and the whole is infiltrated with leucocytes. The lower surface of the crust is composed of a dense layer of pus cells, while the upper epidermal epithelium is generally destroyed or wanting. In the smaller crusts there is less elastic tissue, or this may even be absent altogether, and the epithelial layer frequently remains; the superficial layers being in a state of necrotization. Throughout the crusts are masses of very small micrococci.

Excised portions.—Specimens taken from four of the cases were examined. In these the epidermis alone was involved, or the epidermis together with the subjacent dermis.

The epidermic cells are swollen and in a condition of coagulative necrosis, with vacuolated or completely destroyed nuclei. Their protoplasm is more granular than normal. Sometimes there is only a single homogeneous mass, with vacuoles containing detritus and migratory cells. The whole thickness of the eschar is infiltrated with migratory cells.

On the surface of the lesion and at the borders the cells are flattened and necrotized. The necrosed portion forms a round disc occupying more or less of the thickness of the epidermis.

It is separated from the dermis by a layer of mucoid cells or, when occupying the whole extent of the epidermis, by a layer of pus, cells, or of blood. The blood

occupies generally the summit of the papilla. And there are frequently thrombi and small hæmorrhages in the epidermal eschar.

When the dermis is involved the involved portion is always less wide than the epidermal disc. The process of necrosis is less marked, but the connective tissue is somewhat granular, and the whole disc is infiltrated with small cells. These are more numerous and closely packed at the margin of healthy tissue forming the line of demarcation.

The process probably always begins at the orifice of a hair-follicle. One or more follicles may be involved in a single lesion. The follicle and sebaceous gland are surrounded by small cells, but their epithelium is never destroyed. The sweat-glands are always beneath the seat of necrosis, but are generally surrounded by leucocytes. The hair-bulb is not involved. Outside the necrosed area the lymph spaces are filled with leucocytes for some distance around, corresponding anatomically to the papule which supports the eschar. Neighbouring glands and follicles may be surrounded by small cells.

In the sections masses of *micrococci* were found as in the crusts. They are found only in the necrosed focus, and not in the surrounding tissue. Attempts to cultivate them artificially were unsuccessful. The microbe described by Fordyce was not found.

Etiology.—The disease is less rare than generally supposed (twenty-four cases out of a total of 4,500). The proportion of male to female patients is ten to fourteen; the age twenty-four years to seventy-two years.

It is equally common in rich and poor. In nearly all cases there are digestive troubles. Sometimes the eruption appears at the menopause. Dubreuilh does not agree with Dr. Besnier that it bears any relation to arthritism. The relation to syphilis is not discussed.

Pathogeny.—The earliest morbid phenomenon consists in the formation of a dermo-epidermal eschar. In the youngest lesions excised there is already a line of demarcation more or less pronounced. The papular formation is probably only a secondary reactional inflammation. It seems to be not of vascular origin, for the necrosis does not follow a vascular congestion, and there are no thrombi outside the eschar. It is certainly not of nervous origin. The necrosis, from the first in the form of a plaque around a follicular orifice, suggests that it may be microbic, perhaps aided by auto-intoxication from digestive disturbance.

Diagnosis has chiefly to be made from diverse *syphilides*. The disease must also be distinguished from *hidrosadénites suppuratives disséminées*.

Treatment is generally easy in respect to the existing lesions, but it is difficult to prevent the successive outbreaks.

An ointment of sulphur (about 3j ad 3j) produced a cure of existing lesions frequently in a few days, or at least a week or so, and the author has found no need for more heroic treatment.

In many cases where the disease has been considered syphilitic iodide of potassium internally has been said to give excellent results, but it does not prevent further outbreaks, and a larger dose is required with each fresh crop. Dubreuilh believes, however, that he has been able to control to some extent the appearance of fresh lesions by the administration of ichthyol in doses of thirty to fifty centigrams per diem, or where ichthyol is badly supported, naphthol in ten c.g. doses after each meal.

H. G. ADAMSON.

THERAPEUTIC NOTES.

THE TREATMENT OF PSORIASIS.

DR. COFFIN (*Lo Sperimentale*), in cases of psoriasis of only moderate severity, removes the scales by means of alkaline baths, and then applies the following preparation locally:—

Glycerolate of starch	
Oil of juniper	āā ʒiiiss.
Green soap	gr. 75
Salicylic acid	gr. 45

The affected parts are washed with warm water and tar-soap every three or four days.

When the psoriasis is diffuse and markedly inflammatory, prolonged baths, for six hours, are employed, and mild ointments applied.

When the eruption is limited, he uses Vigo's plaster. In obstinate cases the scales are removed and the following salve applied:—

Ichthyol	
Salicylic	
Pyrogallie	āā gr. xxx.
Vaseline	
Lard	
Lanoline	āā ʒi.

The patient's diet should be regulated, and alcohol, tea and coffee, &c., avoided. Arsenic is given only when the disease has ceased to progress.

THE TREATMENT OF PRURITUS ANI. (*International Journ. of Surg.*)

DR. A. BERGER treats this affection by introducing into the anus a tampon of cotton-wool, from $\frac{1}{4}$ inch to $1\frac{1}{4}$ inch in length, soaked in a solution containing 2 per cent. of hypochlorate of lime. Immediately a slightly smarting sensation has been produced the tampon is removed and the perineum, scrotum and adjacent parts washed with the same solution, which is allowed to dry on the surface. This method is said to relieve the itching almost at once and to produce rapid cure of the eczema frequently present.

THE TREATMENT OF ECZEMA OF THE EAR. (*Revue Internationale de Bibliographie Médicale*, No. 11, 1894.)

IN moist eczema of this region, when the eruption is confluent and situated in the auricle and behind the ear, and in those cases in which a chronic

discharge from the middle ear has caused small vesicles to appear in the meatus itself, Dr. Chatellier recommends that the affected part be washed with a very weak warm solution of bichloride of mercury three or four times daily. After it has been carefully dried with absorbent wool, the meatus should be filled with finely-powdered iodol and the external parts dusted with the same reagent, while a pledget of cotton should be placed in the canal.

In dry eczema, affecting the auricle or the adjacent parts, the mild bichloride wash may be used and the following salve applied :—

R	Iodol	.	.	.	.	.	.	gr. xv.
	Lanolin	.	.	.	.	.	.	ʒi.

When the external auditory canal is involved, the epithelial scales should be removed by irrigation and by means of absorbent wool twisted upon a probe. The canal should then be filled with—

R	Iodol	.	.	.	.	.	.	gr. xv.
	Albolene	.	.	.	.	.	.	ʒi.

and a plug of cotton-wool inserted to assist in retaining the fluid. The dressing should be changed night and morning, and as a rule the eczema will be cured in a fortnight.

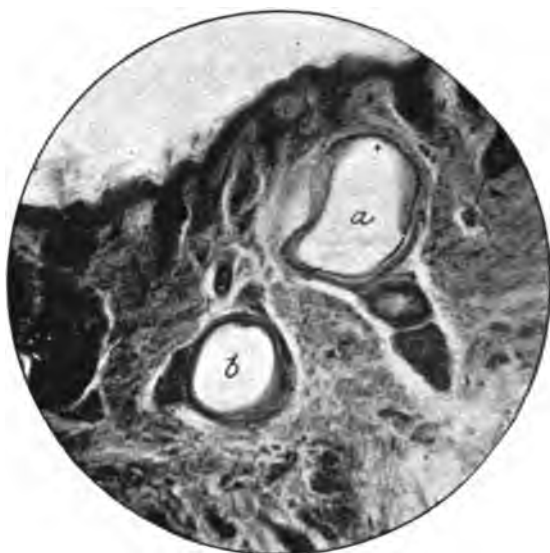


Fig. 1—(a) Cyst just over a coil.
(b) Smaller Cyst in the middle of a coil

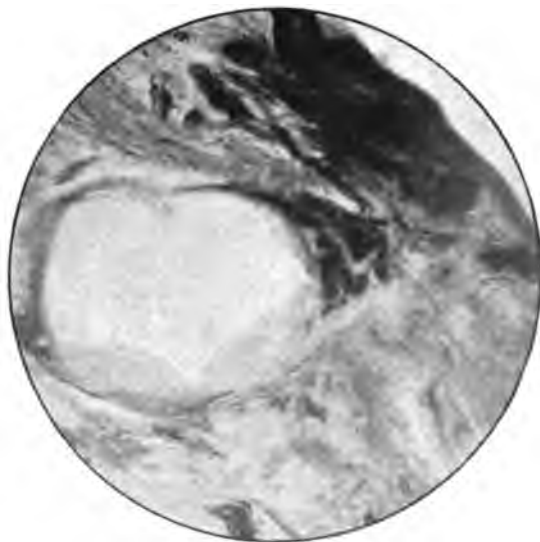


Fig. 2.—Cyst at the bottom of a coil.



Fig. 3.—Dilated coils.

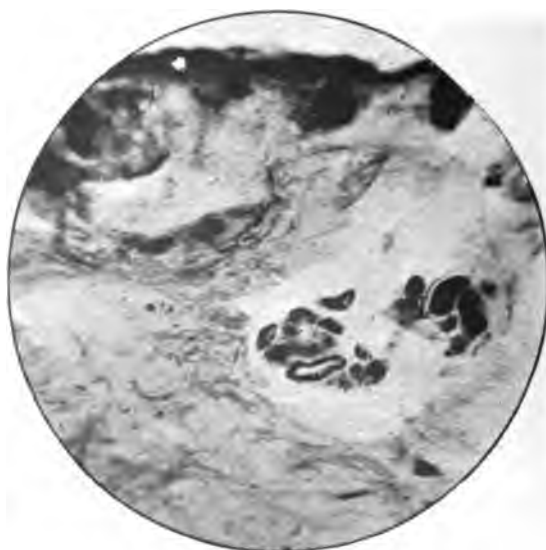


Fig. 4.—Several small cysts in a coil.



Fig. 5.—Intracystic growth.



Fig. 6.—Superficial cyst, (a) hair follicle.

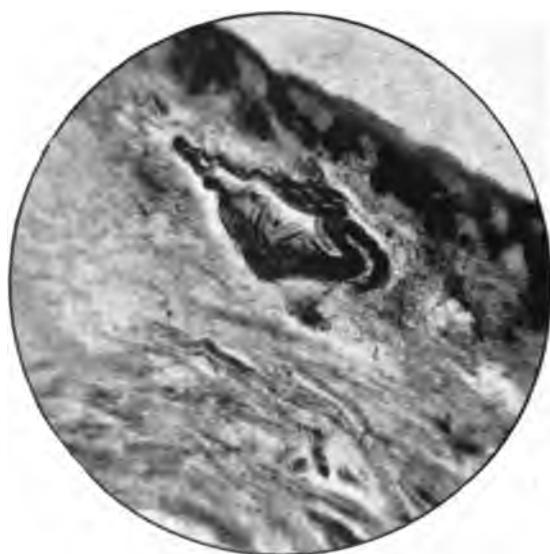


Fig. 7.—Collapsed cyst.

THE BRITISH JOURNAL OF DERMATOLOGY.

JUNE. 1895.

HIDROCYSTOMA.

BY JAMES ADAM, M.A., M.B., C.M.,
Hamilton, Lanarkshire.

IN the number of this Journal for February, 1894, Dr. Radcliffe Crocker, criticizing a case which I had tentatively published in the *British Medical Journal** as one of Lymphangioma Circumscriptum, but with marked differences, came to the conclusion that it was one of Hidrocystoma. I had never seen a case of either disease, had not heard of Hidrocystoma, and was much puzzled by my case; but after, through the kindness of Dr. Colcott Fox, seeing Dr. Robinson's paper on "Hidrocystoma"† I had no difficulty in perceiving that Dr. Crocker's diagnosis was right.

I have now seen nine cases of Hidrocystoma, six in women, three in men. One of the most marked of the cases is the daughter of the patient (Mrs. U.), whose case I have already published. She is also the subject of widespread psoriasis and of severe asthma. Her age is 36; the Hidrocystoma has existed seven years. In two other women, both over 60 years of age, the disease has existed more than twenty years. In one of these, a Scotch lady, the disease began while she lived in Greece, from which she returned only four years ago. She says it is quite common there during hot weather. She states that her son, now aged 14, had it while out there five years

* 2nd December, 1893.

† *Journal of Cutan. and Genito-Urin. Dis.*, Aug., 1893

ago ; he now presents no trace of it. The three cases in men were much less marked and more fleeting. Of these, one, aged 25, had a well-marked vesicle on the tip of his nose ; the other, aged 73, had a similar vesicle in the interciliary region. One of the most pronounced cases was shown to Dr. Alex. Morton, who has charge of the Skin Clinique in Glasgow Royal Infirmary, and who, though he had not previously seen a case, agreed with the diagnosis.

Hidrocystoma, as seen in these cases, corresponds, in most points, to the disease as described by Robinson. The eruption consists of discrete vesicles having a pearly look, like boiled sago grains ; in size varying from a pin-head to a barleycorn ; in shape, spherical, except where, as very rarely happens, two are so closely set that they seem to have coalesced. In slight cases there may be only a few vesicles ; in marked cases, there are hundreds, often closely set and decidedly disfiguring. Limited to the face, the eruption is worse, not on, but around the nose and in the adjacent folds ; next on the temples and upper lip. I have not seen it on the lower jaw. It has no tendency to be unilateral. To touch, the vesicles are painless and surprisingly firm, being evidently deep-set. The epidermis over them does not appear thickened. When pricked they exude a clear, watery fluid, which reddens blue litmus. They then refill with blood, or, especially if quite superficial, simply collapse. The vesicles are most numerous, most prominent and most pearly in appearance during free perspiration ; in a day or two after such perspiration ceases, they diminish in size and the smaller of them may quite disappear. Hence the eruption is less marked in the morning than in the afternoon, in winter than in summer ; during winter it may entirely disappear. In long-standing cases, however, many of the vesicles never disappear. Cysts that might be thought to have quite gone can often be seen by viewing the surface obliquely, and may be more readily felt than seen. I have watched the same vesicle persist for months, even in winter.

All of these patients, save one, were of the thin and active "wiry" type. The exception is the lady who had lived long in Greece, and who, though stout, is of a decidedly nervous temperament. One patient spontaneously remarked that the eruption became less prominent whenever she put on flesh.

Dr. Colcott Fox asks why Hidrocystoma should seem to be more

common in Scotland than in London? This may be partly because, as has been suggested to me, Scotch people, or at least people in the West of Scotland, perspire more than English. There are other considerations why it should have escaped the attention of specialists. It is painless; annoys only by disfiguring, and that mostly in hot weather; it occurs mostly in hard-working people who set little store by their personal appearance. Not one of my cases consulted me because of the eruption.

DIAGNOSIS.—An eruption of discrete, deep-seated vesicles, confined to the face, never larger than a barleycorn, worse when the patient is sweating, and disappearing to a great extent when sweating is at a minimum, ought not to be readily confused with other conditions, once the disease is comprehended as a distinct entity. From lymphangioma cutis and benign cystic epithelioma of the skin (epithelioma adenoides cysticum) Hidrocystoma is distinguished by, amongst other points, the absence of congenital origin, by its limitation to the face, by its rising and falling according as the patient perspires or not; and by the same differences, except that both are limited to the face, it is distinguished from adenoma sebaceum. Pompholyx rarely occurs on the face and is accompanied by heat and itching. Sudamina are so entirely superficial and so readily wiped off that they are not likely to be confounded with the firm, irremovable vesicles of Hidrocystoma. The greatest resemblance is probably to epithelioma adenoides cysticum when confined to the face; but in that disease the little tumours are solid, at least at first, and do not vary in size or number with the perspiration.

PATHOLOGY.—Mrs. U., the patient whose case I published in the *British Medical Journal*, died of heart disease, 30th November, 1894. Pieces of skin, with subcutaneous tissue, were cut from under the inner end of the left eyebrow, and from both naso-oral folds; hardened in Müller's fluid or Formaldehyde, or both, and stained mostly with alum-carmin and picric acid.

An examination of over seventy sections shows lesions as follows:—

Fig. 1 shows two cysts in the subcutaneous tissue. The smaller is close to some muscular bundles, and has parts of its sweat-coil attached on opposite sides of it; nearer the surface is the normal excretory duct. This cyst is obviously *in* the coil. The larger cyst,

richly lined with epithelium, has a sweat-coil below it; but connecting the two is a small cyst evidently formed from a hypertrophied or dilated turn of coil-tube. In another part of the same section (not figured) is a similar cyst with the adjacent part of the coil becoming cystic.

Fig. 2 shows a large cyst, whose epithelial lining has become partly detached in the *deepest* part of the coil, the rest of the coil being between the cyst and the corium, and, as it were, sitting on the cyst.

A very common condition, and what appears to be the beginning of the disease, is seen in Fig. 3. This shows a sweat-coil, several turns of which are much dilated. A further stage is seen in other sections (as in Fig. 4), in which there are several small cysts in one coil.

The epithelial lining of these cysts is always very rich, and is somewhat readily detached. In some cases it forms a true intracystic growth, as in Fig. 5. Possibly this is the explanation of the milium-like changes seen in the older lesions.

Fig. 6 is an example of a very superficial cyst raising up the whole skin, and compressing between its wall and the epidermis a small hair-follicle (*a*). A coil is seen close to it.

Fig. 7 shows a flattened cyst with wrinkled walls, as if it had got emptied of fluid. There are traces of other such "collapsed" cysts in the same section. There is sometimes decided fibrous thickening of the walls of such flattened cysts. In the section from which Fig. 3 is taken there is a large flattened cyst with thick fibrous wall; the epithelium has dropped out.

With a high power the cysts can be seen to have a rich vascular supply; there is usually a number of round cells in the adjacent tissue. Perhaps the most common position for a cyst is just where the coil joins the excretory duct. There is nothing special about the excretory ducts, except sometimes distension with granular contents. The orifices of the ducts seem normal; occasionally there is slight heaping up of the epidermis around them.

These sections show that, as Dr. Robinson maintains—(1) the lesion is one of the sweat-glands; (2) the fluid secreted is sweat; (3) the cysts are not mere retention-cysts.

They seem, however, to go further than his. The cysts in these

sections arise so frequently and so manifestly in the coils that one cannot help thinking that the common mode of origin is first a hypertrophy, then a dilatation, of one or more turns of coil. Such a cyst as the larger in Fig. 1 might readily be regarded as one of the excretory duct, and yet the cystic dilatation just below it shows that it would be as fairly reckoned a cyst of the coil just where the coil joins the duct. Obstruction of the excretory duct has not been shown to exist; even if it had, it would not explain the origin of the cyst at the bottom of the coil in Fig. 2. Even cysts in the upper part of the corium have sweat-coils closely attached to them, though I have seen one at a little distance from what appears to be its coil. Often the larger superficial cysts have a mere remnant of coil, as if most of the coil had gone to form the cyst. The true reading of the disease seems to be hypertrophy of the secretory part of the sweat-glands without compensation in the excretory part for getting rid of the hypersecretion. Distension would result, probably most marked at the seat of the hypertrophy or where the coil joins the excretory duct. When the excessive sweating had ceased, the secretion would be slowly discharged. Hypertrophy once started would tend to go on, as also the resulting distension with each free perspiration. This would explain one striking thing about these cysts, viz., the rich epithelial lining, which is so thick as to be readily detached or even to form an intracystic growth; and which in this way would get time to grow.

Further, these sections seem to confirm the opinion which one is led to form from a clinical study of the disease, that the cysts disappear by slowly discharging their contents and again refill. The "collapsed" cysts, the "swollen" coils, the rich epithelial lining, the fibrous walls of some, all point to this conclusion. One can hardly imagine that such complete structures are formed in the excessive perspiration of a day or a week, to disappear in another few weeks. The cysts collapse probably not by absorption of their contents but by discharge of these slowly through the normal excretory ducts during quiescent intervals.

But still the disease is not quite explained. Evidently the cause which explains the disease must also account for its limitation to the face. The rich vascular and nervous supply which causes the face to

flush and limits flushing largely to the face, although the flush area does not coincide with the distribution of hidrocystoma, as well as the fact that the face is a part exposed to irritation from external influences, may help to explain the disease and its limitation. (Compare the limitation of pompholyx in this respect.) There may also be an individual tendency to this disease as to others.

I am glad to have this opportunity of expressing my thanks to Dr. Colcott Fox and to Dr. Alex. Morton for much kind help.

CLINICAL NOTES.

HYDROA VACCINIFORME *ou* **AESTIVALE**.

BY JULIANO MOREIRA, M.D.,

Physician to the St. Elizabeth Hospital of Bahia (Brazil).

HYDROA VACCINIFORME is so uncommon a disease that I feel that no apology is needed for recording the clinical notes of two cases which I have had the opportunity of studying. These two cases of this rare skin affection are the first described and recorded in Brazil.

CASE I.—Maria B., a white Brazilian, *etat.* 19 years, unmarried, came under my observation first in October 1892.

Family History.—Mother is a stout woman, with healthy skin, who has never had any serious illness; her grandmother and brother had suffered badly from rheumatism. The father's family history was unknown, but he himself was in good health; he is a well-built, robust man.

Previous History.—The patient's health, except as regards the cutaneous affection for which she sought advice, had always been in every respect quite good; she had never had any serious illness.

History of Cutaneous Affection.—The first appearance of her skin disease was referred by her to the summer of 1880 (January), and has come and gone since then. It is nearly absent during the autumn and winter, from March or April till September, and is worst during the summer, from January till March. Any exposure to the irritating influences of the tropical sun-rays produces a more severe outbreak.

Only the exposed regions of the body have so far been affected. In the summer of 1892 the forehead was the part primarily attacked. Afterwards the eruption was disseminated over the chin, the cheeks, the ears and the backs of the hands. The lesions appeared as vesicles and flat blebs, which had no areola.

The primary lesions varied from the size of a pin-point to that of a

split pea. The vesicles were clear, and presented a yellowish hue. The blebs were of a pale-yellowish tint, with a central brownish colouration. After having lasted for several days they dried up to form a brownish scab, ending by covering the whole of the area of the blister. The crust falling off left a cicatrix on the skin often of great depth. The eruption was accompanied by marked itching, but this ceased when the outbreak was fully developed. I only prescribed rest in the bedroom for several days and the application of dermatol powder. The most marked improvement resulted from this simple treatment.

In the summer of 1893 she had a series of attacks from January till March.

In the summer of 1894 a fresh eruption was present from January to the end of February. The cheeks, the nose, and the chin were invaded. The ears and the back of the hands were symmetrically attacked.

On the 25th of December, 1894, after a short walk in the open air exposed to the sun, the eruption broke out again in the back of the hands and spread down to the fingers. This state of things continued until January 15th, 1895, when the dermatitis assumed a more intense character, and spread more widely. Severe, but not constant, itching accompanied the outbreak. The forehead, the nose, the cheeks, the chin and the ears were attacked. The tongue was clean, the temperature normal, the pulse at first 80, but later 75 to the minute. The urine was normal. No sign of visceral disease could be detected.

Confinement to bedroom several days was enjoined. Tonics were the only internal treatment employed.

The local treatment was the application of boric starch poultices till the lesions were clean and all the crusts gone, then painting with steresol.

On January 29th considerable improvement had for the time taken place; nearly all the crusts had fallen off, the face had assumed a perfectly normal appearance as to colour, remaining only rather rougher than normal, but with several vacciniiform scars.

CASE II.—Antonia M., a six-years-old little girl, with a tawny complexion (father mulatto, mother white), came under my observation on December 26th, 1894.

Family History.—Father suffers from asthma, and is a stout man. Mother is healthy, and has three children, all alive. There was no history of syphilis or other skin disease.

Previous History.—The patient's general health had always been in every respect quite good.

History of Cutaneous Affection.—The first appearance of the present eruption was referred by her parents to the summer of 1890 (January), and it has come and gone since then. It is nearly absent in autumn and winter, from March or April till September, and it is worst during the summer. Any exposure to the sun's rays produces a more severe outbreak. Only exposed regions of the body have been affected.

History of the Eruption of last Summer (1894).—The cheeks were the spots primarily attacked. Afterwards the nose, the chin, the forehead, and the forearms were invaded. The eruption appeared as discrete papules, which became vesicles and bullæ, from the size of a pin-point to that of a pea, of a yellowish or greenish colour. After several days they became depressed in the centre; subsequently a brownish crust began to form, ending by covering the whole of the bleb, which, after falling off, left an erosion and often in the end a scar. Severe itching accompanied the eruption. The temperature was normal. There was no sign of visceral disease.

Rest in the bedroom several days was ordered. On the 25th of January the little girl ventured out in the open air; a new outbreak developed, but it was not severe. This time the ears and the backs of the hands were also attacked. I ordered her to be again confined to her bedroom. Tonics were prescribed. The local treatment employed was the application of boric starch poultices till the lesions were clean and all the crusts gone; then painting with steresol. She is at present perfectly well.

It is clear, I believe, that these two cases are of this rare skin disease which was first described by Bazin in 1862. It has been brought again to the attention of dermatologists by Jonathan Hutchinson, in 1888, in the "Clinical Society's Transactions," Vol. XXII.: "A case of summer eruption recurring with great severity for many years, but finally getting well—a form of Kaposi's disease." It has since been observed by Allan Jamieson (1888 and 1894), Henry Handford (1889 and 1894), Berliner (1890), Buri

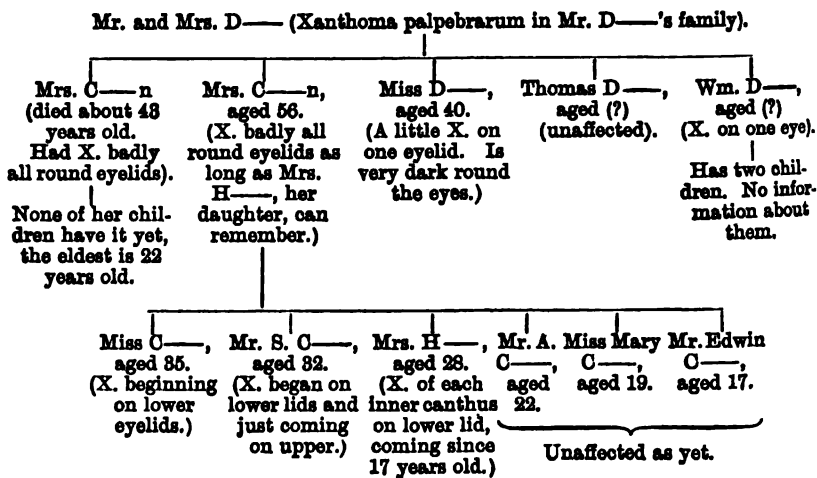
(1891), T. Bros van Dort (1892), H. G. Brooke (1892), Crocker (1893), C. Boeck (1893), John Bown (1894), and Brocq (1894).

HEREDITY OF XANTHOMA PALPEBRARUM.

BY T. COLCOTT FOX, M.B., F.R.C.P.

Physician for Diseases of the Skin to the Westminster Hospital, and Physician to the Skin Department of the Paddington Green Hospital for Children.

Mrs. H—, aged 28, was under my care with Pruritus and Chronic Urticaria, following the prolonged suckling of her third child. My notes say she is not strong, has a weak circulation, and suffers from habitual constipation and leucorrhœa. Her face flushes much after meals, though she does not drink alcohol. She is a brunette with black eyes, and is very dark under the eyes, *as are all her family*. Mrs. H— gave me the information which I have arranged below:—



I have not seen this lady for some years, and unfortunately do not know her address, so that I cannot give the family history up to date.

The heredity of Xanthoma, in connection with the supposition that Xanthomatous lesions are produced by embryonal and local causes, has been discussed recently by Török, who has collected the recorded cases in the *Annales de Dermatologie et de Syphiligraphie*, 3^{me} Sér., T. IV., No. 11, Nov. 1893, p. 1119 *et seq.* Heredity has been noted both in the forms localized to the eyelids, and in the disseminated

form, and Török adds to the cases hitherto recorded a very interesting family history with Xanthoma palpebrarum in three generations. It is especially notable that there was enlargement of the liver with icterus in two Xanthomatous females of the latter family.

MULTIPLE KELOID.

BY T. COLCOTT FOX, M.B., F.R.C.P.

Mr. T., aged 83, consulted me in 1880 on account of widely disseminated keloid growths, chiefly on the trunk and arms. I counted about fifty on the back. There were a good many on the posterior aspect of the upper half of the upper arms, a few on the anterior aspect of this part of the arms, a small number over the chest, and one on the left buttock. The symmetry over the back of the trunk and posterior aspect of the arms was very striking, but not absolute. The growths were of various sizes. Many were much larger in area than a half-crown piece, some as big as a five-shilling piece, and one over the tip of the right shoulder was as big as a split small orange. Some half dozen were mushroom-shaped, with pedicles and overhanging borders, but most were oval, smooth nodular growths. Very few had the characteristic puckered border with outspreading claws. There was no disorder of sensation. Most growths had a pinkish tint, but some were livid with venous congestion. The late Mr. Skey removed nine growths at one period, but all recurred. Mr. T. assured me that one or two growths had disappeared, and that there was a very slow but distinct tendency in many to shrinkage.

The history was interesting as displaying the curious tendency in this patient for scars to take on keloid growth. The grandfather was very gouty, and our patient suffered one attack of gout in the big toe. He had always been very abstemious, and was in the habit of dosing himself a good deal with alkalies. In 1855 (aged 8 years), he cut the inner surface of the upper third of the calf severely. The scar became raised, thickened, and red, but in 1880 had entirely subsided. In 1862 (15 years old), he was lanced several times for an abscess on the outside of the right thigh. Keloid developed extensively in this region, and increased a good deal at the time of the

general outbreak to be presently mentioned. The growth had, however, almost disappeared. In 1865 he contracted syphilis, but there was no scarring from the eruption. In 1869 he had a bubo lanced, and at the same time there was an outbreak of "sores" over the trunk. In the scars left by these "sores" keloid developed, and this was the origin of most of the growths. I could not satisfy myself as to the nature of these "sores," but they may have been rupial. It should be noted, however, that his back was closely studded with acne scars, and indeed in 1890 he still suffered from acne of the trunk, but not of the face. Whatever the cause of the scars Mr. T. affirmed that at the time of the outbreak several old-standing keloid growths enlarged, and many fresh ones evolved quite independently of scars. I should also mention that in his boyhood Mr. T. lacerated the mucous membrane of the upper lip close to the junction with the gums, and also the skin joining the left ear with the scalp. In both situations keloid developed, but subsequently subsided.

Some of these growths might perhaps be considered to be hypertrophic scar tissue, such as one sees after lupus, and in scars left by rupia. The majority were, however, undoubtedly true keloid, and some were quite characteristic of the classical crab-claw form. The distinction between true keloid and hypertrophic scar-tissue is confessedly difficult to make sometimes. Hypertrophic scar-tissue in my experience has a far stronger tendency to undergo involution than in the case of true keloid.

Many striking cases of keloid have been recorded in which the growths have been localized to a particular region, or to only a few sites, but cases of widely disseminated multiple growths are by no means common. The case recorded by Ohmann-Dumesnil was of this nature, and so also the remarkable instance described by de Amicis at the Congrès International de Dermatologie et de Syphiligraphie in 1889. There were 318 growths in the latter case. Professor de Amicis gives several references to other records. I must again point out that multiple hypertrophic scars following rupia are not so uncommon, and belong to a different category.

CRITICAL DIGEST.

THE DISAPPEARANCE AND REGENERATION OF THE ELASTIC TISSUE OF THE SKIN UNDER VARIOUS PATHOLOGICAL CONDITIONS.

(Conclusion.)

THE second of the two essays is by Rud. Krösing of Stettin. This author fortunately treats the subject of the elastic tissue of the skin from the points of view of its normal arrangement, and of its development, as well as from the pathological standpoint, so that a gap in the first essay is filled up, and the two essays form a very good *résumé* of the present condition of our knowledge of processes affecting the elastic tissues.

The importance of the elastic tissue in the skin is first referred to, especially in its relations with the physiological functions being constantly performed by the skin as a tissue containing excretory organs, and also richly supplied with special nerve-organs.

A discussion of the various methods recently adopted for the demonstration of the elastic fibres in the skin is entered into, and especial stress is laid on the striking results obtained by the use of orcein by Zenthöfer, Unna, and others in combination with other stains. By the use of this method the results previously obtained by Unna—who had described three points of attachment for the elastic fibres of the skin, viz., the fascia, the skin muscles, and the “sub-epithelial network”—had been extended in many directions, and the relations of the fibres with all the important skin organs ascertained.

The author then makes reference to the information obtained recently concerning the behaviour of the elastic tissue in diseased conditions, and quotes the main results obtained in various diseases. His own observations were conducted on conditions not frequently examined—such as the eruption of secondary syphilis—and these were chosen on account of the fact that the lesions being evanescent, changes can be followed throughout periods of both degeneration and regeneration.

The first and most complete series of observations recorded are those on papular syphilides. The papules were excised at various stages of development, and the results of their histological examination are given at length. The author arrives at the conclusion that the alteration in the elastic fibres in these papules depends on the intensity of the inflammatory process. In lesions of small intensity their arrangement is disturbed, and slight alterations occur in their size and power of absorbing stains. In more severe lesions the fibres become destroyed, so that they may at length be represented merely as fragments, or as rows of granules lying between the cells.

The author also describes his observations on certain papular varieties of eczema, on lichen ruber planus, on chancreoids, on primary syphilitic lesions, on leprosy, and on certain other skin affections, and discusses the alterations caused by these on the elastic tissue.

As a result of his observations conducted on the developing skin, and on the pathological processes mentioned, the author is able to state :—

1. That the elastic tissue of the skin develops from the intercellular substance in the form of granules about the seventh or eighth month of intra-uterine existence. These granules run together to form fibres, or may, being formed between connective-tissue fibres, cause the latter to be transformed into elastic bundles.
2. That the elastic network of the papillæ appears later than the fibres existing in the deeper layers of the skin.
3. In all the inflammatory lesions that the author has investigated, the elastic tissue of the skin undergoes destruction in relation to the intensity, duration, and amount of the infiltration present, while the walls of the blood-vessels offer a more prolonged resistance to these processes.
4. The early stages of this degeneration is evidenced by the loss of ability to retain specific stains on the part of the elastic fibres, and by their diminution in thickness. In many of the less severe inflammatory lesions the elastic tissues show no farther change, but in more severe degrees of inflammation the destruction of the elastic tissue proceeds apace, and end in the complete disintegration of the fibres.
5. A regeneration of the elastic fibres in its true signification does not seem to occur in the less severe infiltrating processes. The

gradual restoration of the elastic tissue, as the inflammatory lesion lessens, seems to be due to the contraction and shortening of the fibres, which have been pulled apart and diminished in thickness by the pathological process. Along with this there is a return of the power of these fibres to retain distinctive stains. Whether a true regeneration is possible when the elastic fibres have been completely destroyed by long-continued and severe inflammations, and by what means, remains to be investigated.

This essay also is illustrated, but by means of photo-micrographs of sections of various of the lesions described. Many of these show the changes in the elastic fibres with great distinctness, but share the well-known disadvantages of other photographs of pathological sections. The coloured drawings used by Passarge represent the lesions in a much more readily understood manner.

JAMES GALLOWAY.

LETTER FROM PARIS.

BY LOUIS WICKHAM, M.D.,

Chef de Clinique at the Saint Louis Hospital.

XVI.

SOME POINTS IN THE TREATMENT OF SYPHILIS: INTRAVENOUS
MERCURIAL INJECTIONS BY BACELLI'S METHOD.

THE *Société française de Dermatologie et de Syphiligraphie* held its annual meeting in Paris on the 18th, 19th, and 20th of April, during which, on various occasions, interest was especially manifested in various questions relative to the treatment of Syphilis. A communication by Dr. Abadie, of Paris, the distinguished ophthalmologist, on the subject of intravenous mercurial injections, gave rise to an interesting discussion. I think it will be useful to report here a *résumé* of the principal French opinions, but first of all, in a few words, one of Dr. Abadie's communications.

I. INTRAVENOUS INJECTIONS.—Dr. Abadie lauds these injections in the treatment of every case of syphilis. According to him there is no case of syphilis, however benign, which ought not to be treated as energetically as possible from the very start. Intravenous injections having shown themselves to be more efficacious than even subcutaneous injections, in grave and obstinate cases one ought always to resort to them. By such energetic treatment in the earliest stage the serious accidents, which, for the most part, result from the feebleness or absence of early treatment, are diminished.

The following is the *method employed*, a series of which were made before the members of the Society. The solution used was a 1 per cent. solution of cyanide of mercury; the syringe is entirely of glass, including the piston and the plug of the piston, and is made by Luër. It can be perfectly sterilized, and there can be no disaggregation, which might result in the introduction of small solid fragments into the vein.

First, the arm is ligatured about its middle with a handkerchief; the veins of the forearm and elbow swell; the vein is selected; the part to be pricked is cleaned and thoroughly sterilized. The syringe is completely filled; it contains 1 gramme of liquid—i.e., a centigramme (0.01) of cyanide of mercury—the needle is passed through the flame and then introduced gently and in an oblique direction from the epidermis into the cavity of the projecting vein, almost horizontally to the epidermis and following the axis of the vessel. When the cavity of the vein is struck it is quite easily felt; then one stops; the handkerchief compressing the arm is removed, and the piston is slowly pushed down. The syringe is then withdrawn and a light antiseptic dressing, fixed with collodion, is applied, which terminates the operation.

The patients who were operated upon when in our presence seemed to feel nothing and calmly left the room to go to their respective businesses.

Dr. Abadie says it is always so, and he has administered from 400–500 injections. No redness, lumpiness or pain is produced at the spot pinched, either at or after the injection, beyond that which results from a simple prick of the skin. He had never had the slightest accident.

Dr. Abadie gives an injection of 1 centigramme of cyanide of mercury every other day, and continues to do so for three weeks; then he stops all treatment for a fortnight and recommences the series, if necessary. This treatment, he says, is devoid of risk; it is more energetic than subcutaneous or intramuscular injections, and has none of their drawbacks.

In one case of mercurial stomatitis resulting from mercurial inunctions he was able to continue the treatment by intravenous injections, and the stomatitis nevertheless diminished.

Such is, in few words, the communication made by Dr. Abadie. Up to the present no one at St. Louis had had the courage to apply Bacelli's treatment. It often happens that, in order to thoroughly understand new methods of treatment, it is necessary to see them employed; and the members of the Society who had never seen intravenous injections administered were extremely struck with the ease and simplicity of the method.

Before coming to the discussion on the subject I shall resume, in

a few words, the allied subjects which were debated in the course of the general discussion.

II. WHEN OUGHT A SYPHILITIC PATIENT PRESENTING ONLY A CHANCER TO BE TREATED? To this question there was but one unanimous reply "*As soon as possible*," because the more one allows the syphilis to take possession of the individual the greater is the risk of the development of grave tertiary syphilides, as is seen so often in tertiary syphilides of the eye and central nervous system. In a word, a complete agreement is established on the point that, in general, *the absence of treatment is an important factor in the production of severe syphilis.*

But what are we to understand by "as soon as possible"? Is it enough to have determined the presence of a chancre to start treatment immediately? Here there is difference of opinion; some think that one ought to treat at once; if an error in diagnosis is made it will be perceived later on; besides the patient runs very little risk in undergoing mercurial influence for nothing, whereas, on the other hand, he risks much by not being treated immediately if he is really attacked by syphilis.

Others, on the contrary, think—and I believe with reason—that if one treats syphilis as soon as possible one ought nevertheless to treat only when a diagnosis is seriously established. These are they who have seen so many *chancriform* but *non-syphilitic* lesions that they have learnt prudence. At Saint Louis I may say that we constantly remain in doubt in presence of a lesion which appears to be a syphilitic chancre, and which, notwithstanding, turns out not to be so. Indeed the diagnosis of a chancre based upon its objective character only is extremely difficult to establish.

Must one, then, wait for secondary manifestations, roseola? That is going too far, but one must inquire into all the points which may put one on the track: (1) the special characters of the ulcer; (2) the existence and nature of the primary adenopathy; (3) the relation of the date of connection and of the appearance of the chancre, the time elapsed, the chronology of the facts; (4) *Contrôle*, i.e., if possible the determination of syphilis in the person suspected of having transmitted the disease—a most valuable means; (5) the strepto-bacillus of Ducrey and Unna must be sought for to eliminate the diagnosis of soft chancre; (6) lastly, the evolution of the ulceration for a certain

period. These are a number of means which, combined, permit of a strong opinion being arrived at, even in presence of anomalies, without waiting for the roseola which may be delayed or pass unperceived. Thus, *treat as soon as possible, but only when the diagnosis is certain*, such is the opinion of a large majority of French syphilographers.

III. WHAT ARE THE FORMS OF TREATMENT TO PERSONS AT THE BEGINNING? *

Are internal administration, inunctions, or subcutaneous injections to be preferred? On these points opinions are numerous and diverse, and inasmuch as the therapeutics of early syphilis is intimately bound up with that of later stages, it will be impossible for me to pass all in review. On the whole, for treatment in general, we are partisans along with Professor Fournier of treatment at intervals and of long duration—the *preventive method* as contrasted with the *opportunistic method*.

But as the debate at the Society was directed more especially to treatment at the very beginning, I shall confine myself to that. Whatever may be the subsequent treatment *is it necessary at the beginning to treat every case of syphilis energetically, or should they be treated according to their several degrees of severity?* There is one way of harmonizing the different opinions, that is to consider the question from a theoretical and from a practical point of view.

(1) *Theoretically*, all syphilis must be treated with energy, as every one is agreed that the absence of treatment is a powerful factor in the development of grave late syphilis. It is true that, on the one hand, certain cases notwithstanding vigorous treatment from the beginning become grave subsequently. It is also true that certain cases, not treated at the beginning, remain mild throughout. But such cases are exceptional, and do not merit serious consideration.

As regards energy of action, injections occupy the first rank, and among them especially the insoluble injections, such as calomel and blue ointment. Theoretically, all early syphilis should be treated by injections of calomel or grey oil.

* I purposely leave alone the question of extirpation of the chancre. I shall discuss it in another letter. The general opinion in France is that a chancre can be extirpated as long as adenopathy has not been established. But is it possible to know at this period with what one is dealing? And what course ought to be followed subsequently? Ought the patient to be left alone or to be treated?

(2) *Practically*, is it really necessary to insist upon so vigorous a treatment when, by the internal administration of a drug over a prolonged period, according to the method so well studied by Professor Fournier, we obtain such admirable results? Numbers of patients, as the result of this convenient mode of treatment, suffer from no tertiary accidents, and, on the other hand, consider the inconveniences of the treatment by injections!

The substances employed in injection are:—(1) Soluble, *e.g.*, the perchloride and biniodide of mercury, etc.; (2) Insoluble, *e.g.*, calomel, blue ointment, etc.) The former are very easily decomposed (?) (*astreignantes*); the solutions must be made fresh every day or every second day; they are expensive for the patient, very painful, and frequently cause tender indurations at the seat of puncture, so that, in the long run, an extensive area is occupied by these extremely disagreeable nodules.

Insoluble injections are still more dangerous; in persons with idiosyncrasy one runs the risk of grave accidents on account of the accumulation and storage of the mercury in the system. They are sometimes extremely painful. When these methods are employed the patient will often desert the physician and not treat himself at all, for which he will afterwards suffer. With the method of internal administration admirable results are obtained nine times out of ten, the whole point being to know how to direct the treatment. Why not confine one's self to it for simple cases, reserving more energetic and more disagreeable methods for grave and rebellious cases?

Such is the opinion of the great majority of syphilographers, but some add that if it were possible to eliminate the inconveniences of injections by the discovery of a very active and, withal, harmless solution, they would at once accept the view of combining theory with practice and of exhibiting energy from the very commencement. Others think that all inconveniences ought to be passed over disregarded, and injections employed at first.

IV. Suddenly, amidst all these different opinions, the method of Bacelli springs up, by which—as it appears—greater efficiency is obtained, and, at all events, *all the inconveniences of subcutaneous injections are suppressed*. Here we have something pleasing to the majority of French syphilographers, and which reconciled their theoretical ideas with the exigences of daily practice.

The question is an open one ; and now that we have seen in France—thanks to Dr. Abadie—what these intravenous injections consist of and how they are carried out, it will be interesting to study the subsequent evolution of the French therapeutics of syphilis.

In my opinion, in spite of the care bestowed upon intravenous injections, in spite of the excessive attention paid to the various steps in the operation, *is it possible to say that some error may not be committed some day in carrying it out ?* Should that happen it will be a serious matter, and will bring about sudden death by the introduction of air into the veins, or by generalized infection, or phlebitis, etc. I admit that one may have no accident in a thousand cases, but should one of the mishaps which I have enumerated occur it must give matter for serious reflection.

I should, therefore, propose to limit these intravenous injections as well as all subcutaneous injections to serious and obstinate cases, and thus gradually to build up experience. When a certain number of observations shall have been made, and all the minutest details of the operations have been mastered, the method by intravenous injection may be applied to those severe cases in which subcutaneous injections are now regarded by all as being suitable. Thus will experience be multiplied, and if the method proves always satisfactory it may be extended to the treatment of all forms of syphilis, and from the very beginning, which would be ideal. Herein we have, in my opinion, a bright future. If every one applies himself we shall have, in a short time, sufficient experience, but I cannot too strongly recommend, in a matter of this sort, an exaggerated prudence at the beginning of the trial.

SOCIETY INTELLIGENCE.

DERMATOLOGICAL SOCIETY OF LONDON.

At the Annual Meeting, held on May 8th, 1895, considerable changes were carried out in the constitution of this Society.

The Dermatological Society of London was founded in the year 1882, on the initiative of Drs. Sangster and Stowers, by a number of gentlemen specially interested in Dermatology. The objects were the exhibition and demonstration of patients, drawings, models and specimens (microscopical or otherwise) illustrating diseases of the skin, and for the discussion of questions in Dermatology, to be previously selected by the Society. The following are the names of the twenty-three original members:—Sir Erasmus Wilson, Dr. Evan Buchanan Baxter, Dr. John Cavafy, Dr. Stephen Mackenzie, Dr. George Thin, Mr. W. Marrant Baker, Dr. T. Colcott Fox, Dr. W. H. Allchin, Dr. J. Syer Bristowe, Dr. W. B. Cheadle, Dr. Radcliffe Crocker, Dr. Dyce Duckworth, Dr. A. B. Duffin, Dr. C. Hilton Fagge, Mr. Jonathan Hutchinson, Dr. Robert Liveing, Mr. Malcolm Morris, Dr. Joseph Frank Payne, Dr. P. H. Pye-Smith, Mr. Waren Tay, Dr. Frederick Taylor, with Drs. Alfred Sangster and J. Herbert Stowers as Honorary Secretaries. Dr. Wickham Legg, Dr. Thomas Barlow, Dr. Mitchell Bruce, Mr. Clinton Dent, Dr. J. F. Goodhart, Mr. Harrison Cripps, Mr. Marmaduke Sheild, Dr. Penrose, Dr. E. C. Perry, Mr. W. J. Walsham, Dr. D. B. Lees, Dr. J. J. Pringle, Dr. Aldersmith, Dr. Samuel West, Mr. Jonathan Hutchinson, junr., Mr. William Anderson and Dr. Galloway subsequently joined the Society.

Very early in the working of the Society the peculiar advantage and convenience of a limited number of members was felt, and consequently the number was limited to thirty. The meetings were also conducted with as little formality as possible. On these lines the Society has been conducted ever since, and by universal consent the meetings have been peculiarly pleasant and instructive. Nearly 1,600 cases have been exhibited.

For some time the opinion has been growing that from many points of view it was desirable to expand the Society. Such expansion has now been carried out at the recent Annual Meeting, and henceforth there is no limit set to the number of members. The new rule dealing with the election of members is as follows:—

4. *Election of Members.*—Candidates shall be proposed on a form provided for the purpose, and signed by at least three members from personal knowledge, who shall state the grounds of their recommendation, which shall be either (a) contributions to Dermatology; (b) special opportunities for advancing Dermatology; (c) general professional eminence. The names of those proposed as new members shall, in the first instance, be submitted to the consideration of the Council, with whom the power shall rest of declining to allow the nomination to proceed. The proposal paper shall be read at one Ordinary Meeting, and the Ballot shall be taken at the next Meeting but one. No election shall take place unless twenty members vote, and one black ball in ten shall exclude.

The following gentlemen were elected to form an Executive Council for the session 1895-96:—Mr. William Anderson, Dr. Cavafy, Dr. Radcliffe Crocker, Dr. James Galloway, Dr. Robert Liveing, Mr. Malcolm Morris, Dr. J. F. Payne, Dr. E. C. Perry, Mr. A. Marmaduke Sheild, Dr. Frederick Taylor, Dr. Stephen Mackenzie (Treasurer), Dr. T. Colcott Fox and Dr. J. J. Pringle (Honorary Secretaries).

The following cases were then brought forward:—

Dr. JAMES GALLOWAY presented (1) the case of a woman of over 73 years of age, who has suffered during the past four years from an eruption characterized by patches of circinnate erythema, distributed mainly over the trunk, but also over both upper and lower extremities. The patches of erythema lasted for three or four weeks, and when they arrived at their most congested stage developed a bulla, varying in size from a small pea to a hazel-nut, over their central portion. This bulla did not become tense, but remained flaccid, containing a serous exudation. A crust resulted from the bulla, and this, on being detached, left the centre of the erythematous area of the pale colour of normal skin, although there was a certain amount of atrophy of the derma as a result. The erythematous areas gradually vanished, the outer zone of congestion being the last

to disappear. The eruption has produced very little irritation of the skin at any time, and there are no marks of scratching.

The case was regarded by the members present as a case of *Dermatitis Herpetiformis*, with certain anomalous features.

(2) The case of a man of 80 years of age, the sufferer during the past eighteen months from an ulcerative lesion affecting the borders of both nostrils, at the junction of skin and mucous membrane. It had commenced at the posterior extremity of the border of the left nostril, and had crept along the edge of the left nostril round the point of the nose, and had now crept back about two-thirds of the distance along the edge of the right nostril. The edges of the ulcer were extremely verrucose, especially where it had lasted longest. There was an erythematous nodule about the size of a pea, composed of chronic inflammatory exudation, situated on the front of the nose, about one inch above the ulcer.

The case was regarded as one of *Tubercular Lupus*.

Mr. J. HUTCHINSON, junr., brought forward a case illustrating the resemblance a rash due to *Copaiba* occasionally has to a *secondary syphilide*, and the possibility of a mistake occurring if there are other doubtful symptoms of syphilis present at the same time.

The patient was a man, aged 26, who came to the Lock Hospital with phimosis and considerable discharge from under the prepuce (suggesting concealed chancres, the prepuce being hardened towards the furrow at the base of the glans). There was, moreover, slight indolent swelling of the inguinal lymphatic glands. Nearly the whole body was covered by a bright red erythematous eruption, the patches of which were raised and in part confluent. It was most copious on the extensor surfaces of the limbs and on the trunk, but was also present on the face; in fact, no part was wholly exempt. There was but little itching, and the "lean-ham" colour of a syphilide could be said to be present in the earliest patches of the eruption.

He complained of sore-throat, and the fauces were seen to be very congested, as also the soft palate.

It was recognized as being a *copaiba* rash, and on inquiry it was found that he had taken this drug in a haphazard way (without measuring the dose) for three days before the eruption appeared.

It is interesting to note that at the Meeting more than one member expressed their incredulity as to the rash being wholly due to copaiba, and their belief that it would persist some time. The man was kept in hospital a week, and under treatment directed solely against his gonorrhœa (for on slitting up the prepuce it was found that no chancres really existed, but only gonorrhœa and balanitis) the eruption cleared off completely in a few days. It lasted longest on the typical regions (over the ankles and wrists).

So common are cases of copaiba eruption, that probably the mistake is very liable to occur of taking their history for one of secondary syphilis. The patient shown, for instance, would in a year's time relate that he had had some venereal sores, a copious eruption, sore-throat, and felt generally ill; he might even remember that the glands in the groin were swollen. What more likely than to conclude that he had suffered from syphilis?

Mr. MALCOLM MORRIS showed (1) Jane Durham, aged 60. The arms and legs were very red and smooth, and had a glazed appearance. There was no discharge of serous fluid, but there were numerous fine dried scales everywhere, and the fingers on both sides were "peeling" in large flakes. The scalp was also full of scaly material.

The chest and upper part of the back were covered with numerous small red spots, which did not disappear on pressure. The upper part of the upper arm on each side showed an irregular red band, also persisting under pressure.

This condition began about the middle of February, 1895, and reached its maximum about eight weeks later. It was attended with great irritation.

Mr. MALCOLM MORRIS also showed (2) the case of Kate Roche, aged 23. Over the middle of the scalp is a patch of alopecia. This was first noticed at 17 years of age, but may have been present before. It was then as large as the palm of the hand, and grew larger. There were no subjective symptoms. The hair was always dark and coarse. The eyebrows were always thin.

At present the patch is rather larger than the palm of the hand, and is divided symmetrically by a line of short hairs. The hair is black, wiry, and coarse. The skin of the bald patch is smooth and

shiny, and marked by fine lines. The hairs previously mentioned are surrounded at the base by red points, inflammatory in nature. The eyebrows are very slightly marked, and the skin of the scalp and forehead is rough. The diagnosis proposed is *Folliculitis Decalvans*.

Dr. J. J. PRINGLE brought forward a *Case for Diagnosis* in a woman aged 41, who had been under his care for six weeks without undergoing material benefit, although she stated that during the past twelve years she had suffered from about thirty similar attacks which, she asserted, always had yielded in a week's time to treatment. This treatment was ascertained to be Fowler's solution in small doses and a weak boracic acid ointment; it was found to be perfectly inefficacious in the present instance.

She presented on the face several large circular, semicircular and crescentic patches, the centre of which were deeply erythematous and slightly infiltrated, but not scarred. The edges were slightly elevated and covered with abundant yellowish scale. They extended behind the ears and on to the neck, where their crescentic outline and rather dusky tint suggested the possibility of their being syphilitic in nature to some of the members, but this view was not generally accepted, especially as they had withstood the therapeutic test, and there were absolutely no other evidences of specific disease. The largest patch was an almost perfect semicircle occupying the right half of the forehead, its convex margin being directed downwards; it merged into the scalp, which was scaly and pityriasic all over, but especially at the vertex, where the scales were abundant, coarse and greasy. There was no marked alopecia. The patient admitted to very imperfect hygiene of the scalp.

The great majority of members present agreed that the case was a seborrhœic process, and the exhibitor was inclined to think that the name of *Seborrhœa Congestiva* was applicable to it, although not used in the sense originally employed by Hebra as being an early stage of Lupus erythematosus, from which it was clearly defined by the absence of even the most superficial scarring.

The case is yielding, but slowly, to frequent shampooing and mild sulphur and resorcin applications.

THE DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND
IRELAND.

THE Annual Meeting and Congress of this Society was held at 20, Hanover Square, on Thursday, May 30, 1895, the President, Dr. Pye-Smith, F.R.S., in the Chair.

The following gentlemen were elected office-bearers for the year 1895-6:—

President.

PHILIP H. PYE-SMITH, M.D., F.R.S.

Vice-Presidents.

MCCALL ANDERSON, M.D.

J. HUGHLINGS JACKSON, M.D., F.R.S.

ROBERT LIVEING, M.D.

SAMUEL WILKS, M.D., F.R.S.

Treasurer.

ALFRED COOPER, F.R.C.S.

Hon. Secretaries.

J. HERBERT STOWERS, M.D.

LEONARD A. BIDWELL, F.R.C.S.

Council.

WM. ANDERSON, F.R.C.S.

ROBERT L. BOWLES, M.D.

P. S. ABRAHAM, M.D.

A. J. HARRISON, M.B., J.P.

JONATHAN HUTCHINSON, F.R.S.

W. ALLEN JAMIESON, M.D.

STEPHEN MACKENZIE, M.D.

J. F. PAYNE, M.D.

BUXTON SHILLITOE, F.R.C.S.

WALTER G. SMITH, M.D.

WARREN TAY, F.R.C.S.

FREDERICK TAYLOR, M.D.

A full report of the proceedings of the Congress will be given in the next issue of the Journal.

CURRENT LITERATURE.

A CASE OF URTICARIA PIGMENTOSA. DR. L. DERVILLE. (*Journal des Sciences Médicales de Lille*, February, 1894.)

THE patient was a girl aged 10 months. The affection first appeared at the age of 6 weeks, as an eruption of itching papules, most abundant on the back. By the appearance of successive crops the eruption became rapidly almost general. When first seen, at the age of 10 months, the back was thickly covered with slightly raised oval patches of a brownish colour, with here and there maculæ. On the front of the chest the eruption was less abundant, and maculæ predominated. The hands and feet and the mucous membrane of the mouth were free. On the scalp, face, and neck were pale *café-au-lait*-coloured non-raised patches.

Slightly enlarged glands in neck, axillæ and groins.

On local irritation, the papules became tumid, and resembled urticarial wheals. When the child cried, or on removing the clothes, the whole skin surface became congested, with severe itching.

The urticarial symptoms were relieved by treatment, but the eruption itself remained unchanged.

H. G. ADAMSON.

PRIMARY SARCOMA CUTIS AND SUCCESSFUL TRANSPLANTATION.

DR. CAMILLO MAGLIANO. (*Morgagni*, XXXVI, May, 1894.)

The patient, male, æt. 68, single, was the subject of primary multiple pigmented sarcoma of the skin. The family history threw no light on the affection; he stated that he first noticed the skin of the left foot to become red and irritable. Some months after the right foot was similarly attacked. The disease in the course of some years gradually spread, and when he came under Dr. Magliano's observation presented the following characters. The eruption was macular and nodular in type, and resolved itself into four divisions: (i.) slight thickening of the skin, not changed as to colour; (ii.) diffuse thickening with alteration in colour; (iii.) tubercles more or less raised above the surface; (iv.) nodules distinct and circumscribed.

The nodules varied from a lentil to a vetch-grain in size, from deep-red to reddish-brown in colour, which persisted after pressure. Many of these were grouped, and some seemed to be wedged into the cutis. Here and there the epidermis was broken, and a small ulcer was present on the apex of the nodule.

The tubercles were larger, varying from a nut to an almond in size, and presented similar characters to those of the nodules. The ulcerated apices were covered with dirty yellow crusts, on removal of which a sero-purulent surface was exposed. The tubercles were very painful to the touch. They were hard and could be fairly well isolated from the surrounding skin, which frequently presented a violaceous hue.

The various indurations, i. and ii., had a parchment-like consistency, and in some places extended to the subcutaneous tissue; their colour varied considerably, from a bluish to a fiery red, more or less "shot" with yellow. Tactile and

thermic sensibility were generally normal over the affected areas, which were, like the tubercles and nodules, painful. The distribution of the disease was as follows:—

Head.—Three pigmented growths on the right cheek; two on the left, one non-pigmented growth on the left ala of the nose, and one on the right orbital region. There were also macular teleangiectases on both cheeks and right half of the forehead.

Chest.—A dark-red growth, slightly raised at the junction of the ensiform cartilage with the sternum, a pigmented growth near the inferior margin of the left pectoralis major; there were also scattered over the upper part of chest more or less perceptible maculae. Posteriorly, three growths (two pigmented), lentil in size, on the left half, and several very small pigmented spots on the right half of the chest.

Abdomen.—A growth in the left lumbar, and one in the left iliac region.

Left Upper Extremity.—Three lenticular growths on the external aspect of the arm; a growth on the flexor aspect of the radial side of the wrist; also an induration of the size of a sixpence, dark-red, in the same region. On the dorsal aspect of the hand there was a diffuse thickening extending from the wrist to the little finger. The palmar region showed the thickening extending along the palmar aspect of the same digit. The skin over the thenar eminence was similarly indurated and pigmented.

Right Upper Extremity.—On the arm, five pigmented growths anteriorly, four posteriorly. *Forearm:* two on the external and two on the internal margin adjoining the wrist. *Hand:* dorsal aspect; slight diffuse thickening, reaching as far as the metacarpo-phalangeal joints of the index and middle finger. Palmar aspect showed a slight induration over first phalanx.

Right Lower Extremity.—*Thigh,* anterior surface: a pigmented growth near the knee, and two linear marks over the knee; internal surface: two growths, one in the middle, the other near the knee; posterior surface: one in the upper third of this region.

Leg.—The anterior surface of lower third showed a parchment-like induration of a dark-red colour. Externally, there were similar patches, some confluent, others discrete and raised so as to form nodules. *Foot,* dorsal aspect: a large ulcerated area concealed by a crust.

Left Inferior Extremity.—*Thigh,* anterior surface: a pigmented growth on lower third; internal surface: three on the upper third.

Leg and Foot.—Several nodules, some ulcerated and covered with crusts. The hair and nails show nothing abnormal.

The lymphatic glands of the submaxillary region were slightly enlarged. The femoral glands of the left side were also increased in volume, but were not fused. A microscopical examination revealed sarcomatosis cutis.

Dr. Magliano succeeded in transplanting portions of the nodules to areas where the skin was free. He gives full details of these experiments and demonstrates their success by histological methods. He concludes that from a therapeutic point of view these experiments do not avail much; on the other hand, where the nodules are not too numerous, they might be excised with a good prospect of cure. He urges in such cases the administration hypodermically of arsenic. As regards the question of these tumours being related to the granulomata, he has no evidence to bring forward either for or against this view.

FRANK H. BARENDT.

THE DIFFICULTIES OF THE TREATMENT OF *TINEA TONSURANS*.

HENRI ALEXANDRE MARTIN. (Steinheil, Paris, 1894.) *Thèse de Paris*.

1. The author examines the various methods of treatment of tinea, and concludes "that there does not exist at the present time a satisfactory treatment for tinea tonsurans."

2. He gives a summary of Sabouraud's recent work, and accepts all his conclusions. From the doctrine of plurality of species it follows that such treatment cannot be specific, for there are many varieties of tondants, each of which requires a special therapeutics.

3. Since cases will ultimately recover spontaneously, it is not justifiable to employ methods which cause destruction of the hair-follicles, and which lead to the formation of a hairless cicatrix.

4. Unfortunately, of the methods at present known, those which spare the follicle are unable to attack the parasite, on account of the deep implantation of the hair and the narrowness of the mouth of the follicle.

5. The difficulty in diagnosis, especially of early cases, is pointed out. In the earliest stages the hair does not appear to be altered. The lesions may easily be confounded with seborrhoea, psoriasis, impetigo, etc. In suspected cases he advises that the head should be painted with tincture of iodine, for this not only enables one to confirm the diagnosis, but brings into prominence the earlier lesions, destroys them, and acts as a prophylactic to the further spread of the disease.

6. It is even more difficult to decide when a case is cured. A cure can only be declared when two careful examinations, at an interval of one month at least, do not reveal any parasite; even then one may be deceived.

7. The difficulties of treatment and the extreme contagion demand energetic prophylactic measures. The management of epidemics in schools is thoroughly discussed, and the establishment of state hospitals for isolation is strongly advocated. It is not sufficient, however, to isolate tinea cases; the different varieties should be kept apart.

8. In all cases the preliminary measures recommended by most authors should be carried out, viz., the head shaved, washed daily with soap and warm water, and kept covered by a bonnet or cap. In all cases the head should be painted with iodine for the reasons given above.

1. *Large-spored varieties of animal origin*.—The tendency of these forms is to cure themselves by a process of inflammatory diminution, complete alopecia not resulting unless the inflammation be very intense. The primary indication for treatment is therefore to control the irritation by meal poultices, which have also the advantage of removing crusts, etc. Where there is little or no folliculitis it is necessary to provoke slight irritation. This may be done by the application of an iodine ointment (8 to 20 in 100). The duration of these cases is from two to four months.

2. *Large-spored varieties of human origin*.—Treatment by irritants seems to be the best at the present time. The fungus in this form is almost exclusively confined to the hair, and epilation is recommended, together with the application of tincture of iodine and Vigo's plaster. Though complete epilation is difficult, yet one obtains a bald patch, allowing easier application of the plaster, and perhaps also the entrance of the iodine into the follicle is facilitated. The results of this method are to cause (1) a vesicular inflammation; (2) or a deeply-seated exudation.

These remedies act probably by producing a secondary pus infection antagonistic to the growth of the fungus.

In cases of fragile mycelium, where the hairs often do not pierce the integument, rendering epilation impossible, it is well to remove the superficial epidermis by means of shaving, scraping, iodine applications or collodions.

In those cases where there are no large plaques, but small groups of diseased hairs scattered over the whole scalp, gauze dressings appear useful. A thick cap of iodized wool can be applied to the head and covered with oilskin.

8. *Small-spored variety*.—Here there exists the same difficulty in epilation and the same impossibility of reaching the bottom of the follicle.

According to Sabouraud, the staphylococcus has no deterrent effect on the growth of the *microsporon*, and does not cause deep inflammation of the scalp. Martin entirely agrees with Sabouraud, and says, "we must, therefore, look for other treatment than that of irritative medicaments."

The best results have been obtained by the alternate application of tincture of iodine and a pomade of carbonate of potassium. The pomade facilitates the epilation of the hair, so that at the end of three weeks or so *by using great gentleness and care*, the hairs can be epilated almost or quite entire, and thus facilitating the penetration of the iodine into the follicle. The duration of this type under such treatment is not definitely stated.

4. *Treatment of the last stage of tinea tonsurans*.—In all cases, after arriving at a certain stage of cure, there remain isolated spots of a few hairs which may resist all treatment. It is justifiable then to destroy these hairs by needling or electro-cautery.

H. G. ADAMSON.

ON A THIRD CASE OF CHRONIC VEGETATING PUSTULAR DERMATITIS, WITH EXCENTRICALLY PROGRESSING FOCI. MM. H. HALLOPEAU and LE DAMANY. (*Annales de Dermatologie et de Syphiligraphie*. January, 1895.)

THE authors showed, at the Société Française de Dermatologie et Syphiligraphie, a case which they believed to belong to the same morbid type as two previous cases published under this title.

The patient, aged 19 years, had suffered three years previously from an intestinal affection, characterized by frequent bloody and diarrhoeic stools and abdominal pain. He had since been subject to attacks of diarrhoea at irregular intervals.

On admission to hospital, in October, 1894, there were two large irregular eruptive patches, one occupying the chin, the lower part of the sub-hyoid region and the lower part of the right cheek, the other the left cheek in front of the ear. The former had arisen by the coalescence of two separate lesions arising on the chin and right cheek.

The lesions were raised, vegetating, red, covered with crusts, pus and pustules. The vegetations were present over the whole surface, closely placed on the chin, but less abundant on the cheeks. They were raised 1-4 mm., and the summit of each was occupied by a small vesico-pustule, or excoriated and covered by sero-purulent discharge or crusts.

The mucous membrane of the nose was thickened, and the orifice of the nares occupied by ulcerated or crusted vegetations. On the inner surface of the lips

were agglomerated vesico-pustules, with red and excoriated surface between. The pharynx and buccal mucous membranes were unaffected. The centre of the tongue was occupied by an antero-posterior hard sinuous ridge, with lateral branches directed slightly forwards, and with induration of the intermediate parts. There was slight itching of the skin lesions, most marked at night.

After a few days' local treatment the skin plaques subsided considerably, but meanwhile fresh vesico-pustules appeared upon the cheeks and scalp, producing by their centrifugal extension the following lesions :—

On scalp—Greyish crusts, about 1 c.m. in diameter, on a red and oozing skin.

On the right cheek—A red plaque, 8 c.m. by 4 c.m., covered with yellow, soft crusts. Other plaques consisting of a central erythematous portion with a bulla, or the remains of a bulla, at the margin; the central part supporting small vesico-pustules, and in one plaque tiny vegetations. Behind the right ear the remains of a bulla. Behind the angle of left jaw a small plaque with typical vegetations. The original lesions are disappearing though vegetations remain, especially abundant upon the chin.

There is no change in the lesions of mouth and nose, except that there are fresh pustules, together with some vegetations, analogous to those on the skin, on the inner surface of the cheeks.

The case resembles those previously described in the arrangement in asymmetrical foci—beginning, persisting, and extending by the formation, usually of vesico-pustules, exceptionally of bullæ; in the vegetative proliferation of the dermis on their surface; in the implication of the lips and buccal mucous membrane with sclerosis of the tongue.

From Duhring's *Dermatitis herpetiformis* it differs in the extension of its lesions exclusively by local multiplication, in their asymmetry, in the constant presence of persisting vegetations, and in their response to local treatment. From Neuman's *Pemphigus vegetans*, in that the elementary lesion of the latter is always a bulla with fetid contents, and that the prognosis is always very grave.

The authors summarize their conclusions as follows :—

1. The vegetations of the lesions, as well as the pustular changes and the sclerosis of the tongue, must be considered as constant and pathognomonic elements of *chronic pustular Dermatitis with excentrically progressing foci*. These constitute a characteristic symptomatic triad;
2. It is proposed to add the epithet of *vegetative*;
3. The nares may be affected and blocked by these vegetative growths;
4. The eruption may be polymorphous, and made up of bullæ as well as of vesico-pustules: these latter are always the predominant elements;
5. The general health of the patient is good;
6. One finds in abundance in the exudation the *Bacterium Coli Commune* in a virulent condition; it is possibly the immediate cause of the morbid changes.
7. In spite of apparent analogies, this disease differs from both *Dermatitis herpetiformis* and *Pemphigus vegetans*;
8. It is amenable to local treatment.

In the discussion following the paper M. L. Brocq was of opinion that one of the cases quoted by M. Hallopeau was a typical example of *Dermatitis herpetiformis*, in which the vegetations were only an accessory phenomenon, having appeared only at a late period and at very limited points.

H. G. ADAMSON.

Fig. 1.

PLATE I.

Fig. 2.

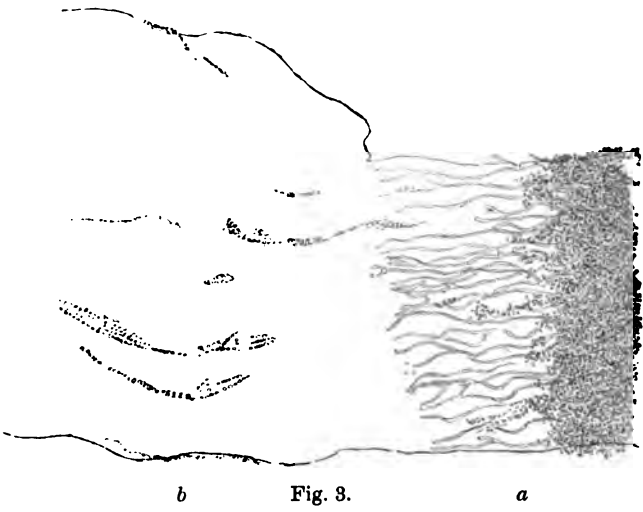
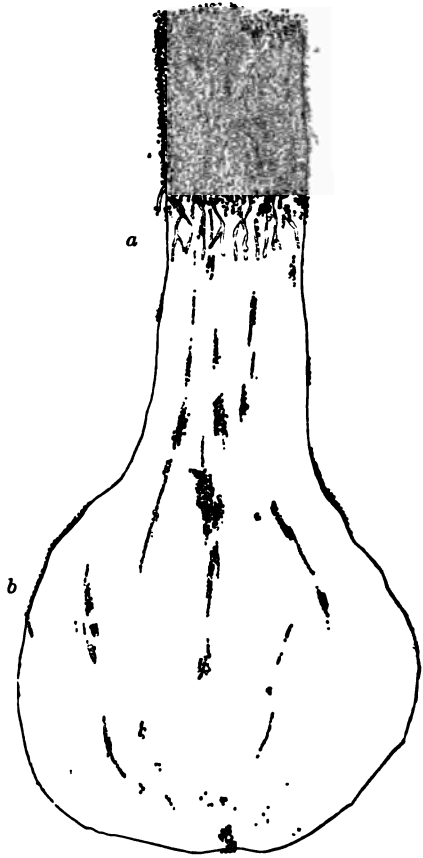
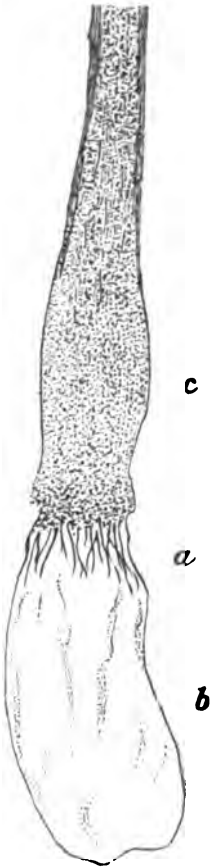


PLATE II.

Fig. 4.

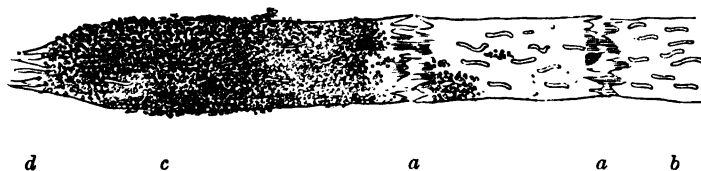


Fig. 5.

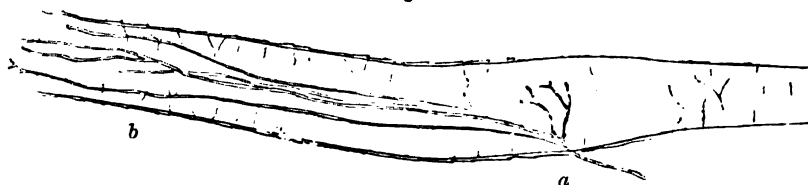


Fig. 6.



DESCRIPTION OF PLATES I. AND II.

Fig. 1.—Root of hair under low power. 1 inch objective. *a*. Fringe of mycelium, which is continued upwards beneath the spore-sheath. *b*. Bulb with rows of spores upon its surface. *c*. Sheath of spores.

Figs. 2 and 3.—Hairs under higher power. $\frac{1}{4}$ inch objective. Reduced one-half. *a*. Mycelial threads, branching in a downward direction. *b*. Bulb with rows of spores as before.

Fig. 4.—Hair epilated without extracting the soft bulb. $\frac{1}{4}$ inch objective. Reduced one-half. *a a*. Cross fractures on aerial portion. *b b*. Broken rods of mycelium on aerial portion. *c*. Sheath of spores surrounding follicular portion. *d*. Ragged fracture above the neck of the soft bulb detached.

Fig. 5.—Cuticular covering of hair-shaft, pierced by mycelium in earliest period of invasion. *a*. Point of entrance of mycelium. *b*. Mycelium passing downwards immediately beneath the cuticle towards the bulb and terminating at neck of the soft bulb.

Fig. 6.—Hair in intermediate stage of invasion. *a*. Short chains of larger elements. *b*. Small spores of sheath.

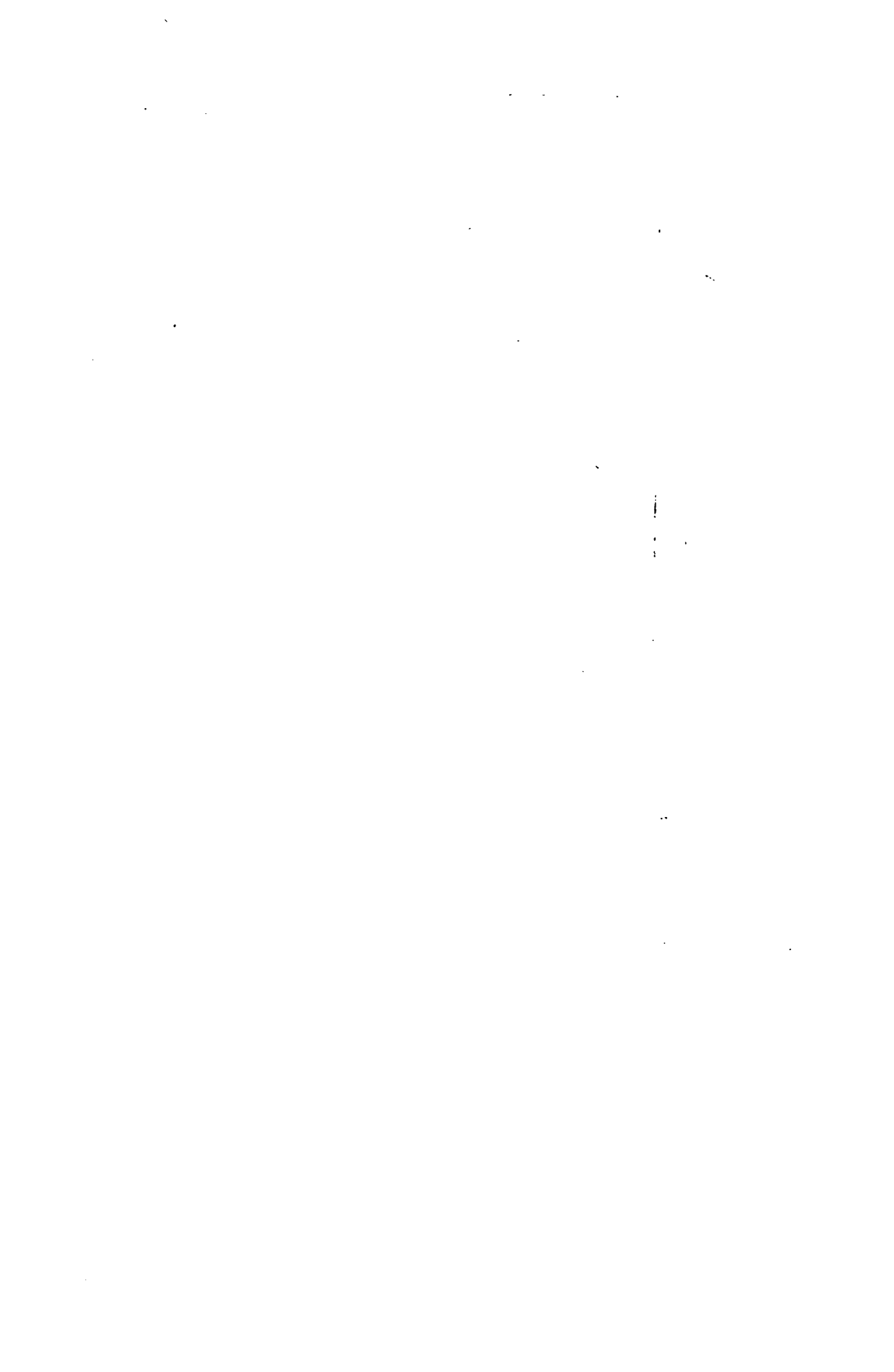


PLATE III.

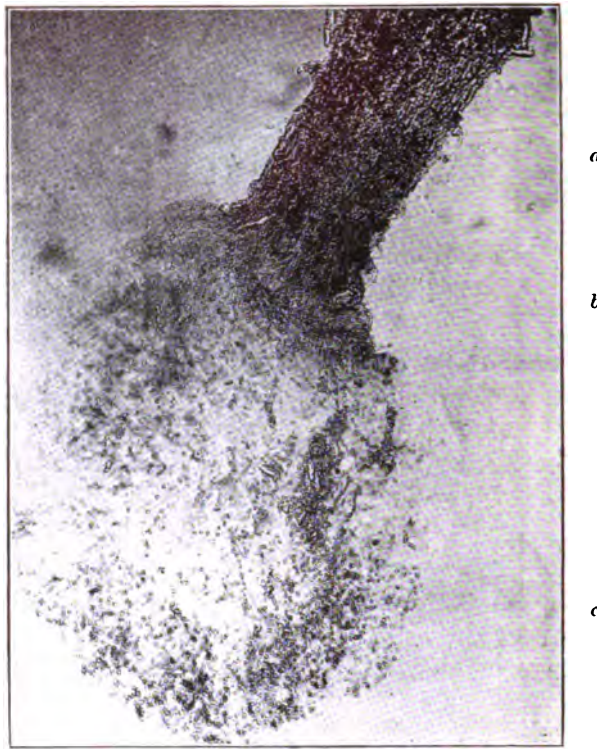


Fig. 7.

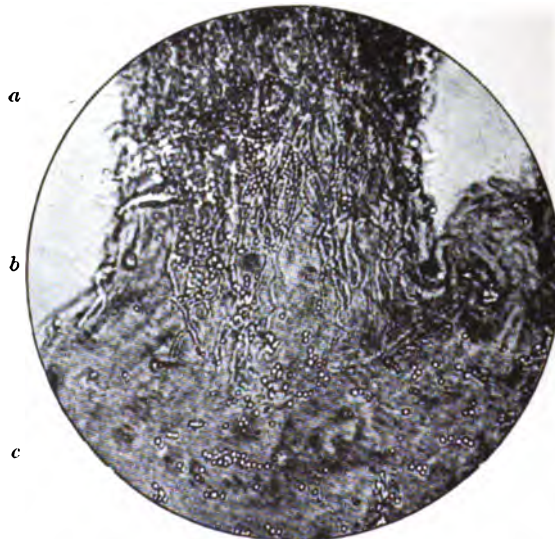


Fig. 8.

Fig. 7.—Hair showing lower end of root-stem and soft bulb. [$\times 90$.] *a*. Sheath of small spores round root-stem. *b*. "Fringe" of mycelium at neck of soft bulb. *c*. Spores on surface of soft bulb. (The detail of the original micro-photograph at (*a*) and (*b*) is not shown in the above illustration.)

Fig. 8.—Hair from same case, showing "fringe" of mycelium more distinctly. [$\times 200$.] *a*. Spore-sheath. *b*. Mycelial fringe. *c*. Spores on bulb.

PLATE IV.

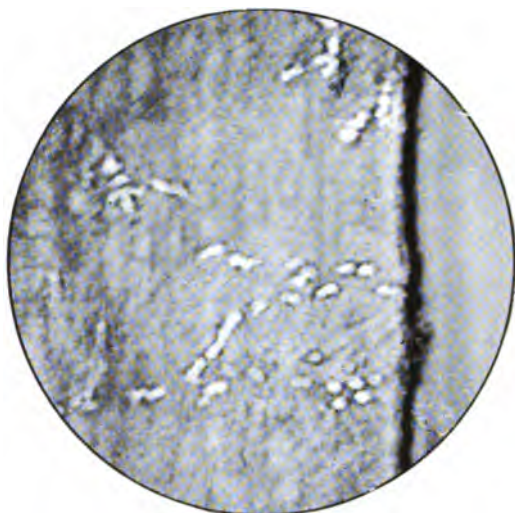


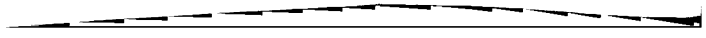
Fig. 9.



Fig. 10.

Fig. 9.—Hair from "small-spored" ringworm, early stage, showing "ghost-like" larger elements at upper part of root-stem. [X 300.]

Fig. 10.—Hair at quite early stage of attack before formation of "spore-sheath," showing mycelial "fringe" at junction of root-stem with neck of soft bulb. The mycelium lies immediately beneath the cuticle, which remains intact. [X 300.]



THE BRITISH JOURNAL OF DERMATOLOGY.

JULY, 1895.

OBSERVATIONS ON THE PARASITES OF RINGWORM.

BY H. G. ADAMSON, M.D. (LOND.), M.R.C.P.

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THE brilliant researches of Mons. Sabouraud,* of Paris, have of recent years attracted attention to the study of the mycology of ringworm, and have stimulated research in almost every country where that obstinate affection is epidemic. The subject has been discussed at length before a meeting of the German Dermatological Society,† by Pick, Behrend, von Sehlen, Jadassohn, and others, while Rosenbach,‡ Furthmann and Neebe§ in Germany, and Leslie Roberts|| in this

* Sabouraud (1) "Contribution à l'étude de la Trichophytie humaine," *Annales de Dermatologie*, November, 1892; (2) "Sur les Trichophytons à grosses spores," *Annales de Dermatologie*, February, 1893; (3) "Sur la Folliculite agminée trichophytique et son Origine animale," *Annales de l'Institut Pasteur*, June, 1893; (4) "Sur les Trichophytons de la barbe," *Annales de Dermatologie*, July, 1893; (5) "Trois points de l'histoire micrographique des Trichophytons," *Annales de Dermatologie*, November, 1893; (6) "Sur une Mycose innommée de l'homme," *Annales de l'Institut Pasteur*, February, 1894; (7) "Les Trichophyties humaines," Paris, 1894 (Rueff, Éditeur).

† *Verhandlungen der Deutschen Dermatologischen Gesellschaft*, Fourth Congress, May, 1894, pp. 54-115; Pick, "Der augenblickliche Stand der Dermatomykosenlehre." Winternitz, "Ueber eigenartige Trichophyton-Culturen." Krösing, "Studien über Trichophyton-Culturen."

‡ "Über die tieferen eiternden Schimmelerkrankungen der Haut und über deren Ursache," F. J. Rosenbach, Wiesbaden, 1894.

§ Furthmann u. Neebe, *Monatshefte für praktische Dermatologie*, 1891, No. 11, p. 477.

|| "The present Position of the Question of Vegetable Hair Parasites," Leslie
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country, may be perhaps mentioned without invidiousness as having largely contributed to our knowledge.

The main object of this paper is to discuss *the anatomical relations of the fungus to the hair* in ringworm, and the important question of plurality of species—so far as the artificial cultivation methods of determining it are concerned—will not here be considered.

In reviewing the clinical and microscopical appearances it will be noted, however, that cases can be readily grouped according to different microscopical pictures presented by the affected hairs, and corresponding to different clinical conditions. The microscopical appearances are constant for the same individual case, and for those produced by contagion from it. In no case are the different appearances found upon the same scalp or chin at the same time, nor does one form ever pass into another at different periods of the disease.

The microscopical appearances here alluded to are those of a hair when completely invaded by the fungus, as is the case in the majority of hairs over any diseased area. Hairs in a quite early stage of attack do indeed present resemblances in the different forms, but it is a curious fact that such hairs are only obtained by careful searching, and even in them characteristic distinctions can generally be made out.

As Sabouraud has recently pointed out, Gruby* was the earliest observer accurately to describe the fungus of ringworm, and to recognize its different microscopical appearances in different clinical groups.

Gruby's descriptions correspond closely with the three main forms in Sabouraud's classification, viz.—(1) The small-spored variety, *Microsporon Audouini*, forming a sheath of spores round the hair; (2) The large-spored variety, *Tricophyton megalosporon endothrix*, in which the spores are confined to the interior of the hair-shaft; (3) The large-spored variety, *Tricophyton megalosporon ectothrix*, in which the fungus is situated outside the hair.

After Gruby described these varieties until the publication of Sabouraud's work, many observers had carefully studied the fungus

Roberts, *British Medical Journal*, September 29, 1894, p. 685; Annual Congress of the British Medical Association, Newcastle, August, 1898; *British Medical Journal*, August 26, 1898.

* Gruby, *Comptes rendus*, Paris, 1841, t. XIII, p. 79; 1842, t. XV, p. 512; 1843, t. XVII, p. 801; 1844, t. XVIII, p. 583.

of ringworm, and yet the general opinion was to regard the fungus as identical in the several clinical forms.

It is only here and there in the literature of ringworm during that period that one meets with any reference to large and small spores, and then they were only looked upon as representing different stages in the life of the same fungus.*

If these distinct forms do exist, and are so clearly recognizable by microscopical examination, one naturally asks why they have been overlooked during so many years and by so many careful observers.

On turning to their descriptions or drawings of the fungus, it will be found that either they are indefinite and the drawings apparently made from imperfectly prepared specimens, so that they cannot be compared with either of the forms described by Gruby and by Sabouraud, or else, where the descriptions and drawings are more careful and accurate, that they correspond to one or other of these groups. In the plates of Bazin, for example,† the drawings, although excellent in technique, have evidently been made from badly-prepared specimens, while the fungus and broken hair are so mixed together that their real relations to one another cannot be made out. On the other hand, in the plates of Malmsten‡ and of Bärensprung,§ hairs are seen which correspond exactly with the description of Sabouraud's *Tricophyton megalosporon endothrix*, while in Dr. Frederick Taylor's article in the "Medico-Chirurgical Transactions" for 1879, there is an excellent drawing of a section of a scalp affected with ringworm, in which the appearance and situation of the fungus is precisely that of Sabouraud's small-spored variety.

The explanation of this confusion of dissimilar forms seems to be twofold: (1) The methods of preparation of specimens have been faulty, or (2) the greater prevalence of one particular form of fungus in the country or locality from which the observer's cases were drawn. It will presently be shown that very small faults in the preparation of specimens may obliterate the true relations of the

* *Dictionnaire Encyclopédique des Sciences Médicales*, Dechambre, Paris, 1885, T. 18, page 190; Article "Trichophytie," Ed. Juhel-Rénay; Balzer, *Archives générales de Médecine*, October, 1886; Requin, *Eléments de Pathologie générale*, T. III., 1852.

† Bazin, *Affections cutanées parasitaires*, Paris, 1858.

‡ Malmsten, *Müller's Archives*, 1848.

§ Bärensprung, *Annalen des Charité-Krankenhauses*, December, 1855, p. 116.

fungus to the hair. That the various forms may be more or less prevalent in different localities will be seen by comparing Sabouraud's statistics with those presently to be given.

Sabouraud has stated the proportion of small-spored to large-spored fungus in ringworm of the scalp among his patients in Paris as being twelve to eight. In 178 successive cases observed at the Middlesex Hospital and the North-Eastern Hospital for Children, upon which the observations in this paper are founded, there were only seven instances of large-spored forms—*i.e.*, a proportion of small-spored to large-spored as 24 to 1.

The three main types recognized by Sabouraud can always be readily distinguished by microscopical examination, viz.:—(1) The small-spored ectothrix (*Microsporon Audouini*); (2) the large-spored endothrix; (3) the large-spored ectothrix. This general classification will be adopted for convenience' sake, and because the results of the observations here recorded agree in the main with those of Sabouraud. As will be shown, however, the division into endo- and ecto-thrix forms is not wholly correct, for although there are marked differences in the appearances presented by the hairs when completely invaded, yet the relations of the fungus to the hair are essentially alike in both at an early stage of the invasion. Differences in the mode of growth of the various forms produce in the later stages characteristic differences of appearance, some forms growing with greatest luxuriance inside the hairs, whilst others flourish most abundantly on the outside of the hair. In the small-spored variety the elements seem to flourish more luxuriantly outside the hair, thus forming the "spore-sheath." In the endothrix form the external sheath early disappears, and the fungus within the hair grows rapidly; while in cases which seem to correspond to those which have been called by Sabouraud the *Tricophyton megalosporon* ectothrix, the fungus actually grows equally freely inside and outside the hair.

Before entering into the details of these relations, the *method of examination* followed will be described.

The usual method of examining hair in ringworm is to clear the hair with liquor potassæ, and this has been the method adopted. It is of the utmost importance, however, to accentuate the fact, that, in order to preserve the relations of the fungus to the hair, certain precautions, trivial as they may appear, must be taken. The proce-

ture generally described in text-books and almost universally adopted is to soak the hair for a length of time—fifteen to twenty minutes—in liq. potassæ (B.P.) or ether, or both, and then to examine them either in the potash solution or in glycerine. It is usually also recommended to press down the cover-glass in order to flatten out the hair. By doing so, however, the softened hair is broken up, so that the true relation of the fungus to the hair becomes indistinguishable. Again, I have observed, ever since I undertook this research a year ago, that when mounted in glycerine some of the elements become invisible,* and this is especially the case with the mycelium in the *small-spored* variety. The use of a strong potash solution and the procedure of heating, both recommended by Sabouraud, are not only quite unnecessary, but absolutely harmful to the specimen. The process of heating tends to soften the hair too much and to render it cloudy, and when the soft bulb is present this becomes altogether detached and destroyed. A much more satisfactory result is obtained by using a weak potash solution (5 to 10 per cent.), such as the B.P. solution, which is about 6·8 per cent. The preparation can then be examined *during the process of clearing*, and any alterations in the relations of the fungus and hair from softening of the specimen can be detected. Again, in a 40 per cent. solution the mycelium (at least in the *small-spored* variety) cannot be seen. Sabouraud, who at first denied the existence of mycelium in the *small-spored* variety, has only lately been able to demonstrate its presence, and that by a very complicated method of preparation, whereas if the hair is mounted in a weak solution the mycelium is readily observed and in its normal relations to the hair. The explanation of this fact, and of the fact that the mycelium cannot well be seen in glycerine preparations, is probably that the density of the strong solution and of the glycerine correspond nearly with that of the mycelium, for, if the 40 per cent. solution be washed away with water the mycelium at once becomes plainly visible.

The important practical points, therefore, are:—(1) To use a weak solution of liq. potassæ, (potassium hydrate, 5 per cent. to 10 per cent.); (2) to place the hair directly on the slide and examine *during* the process of clearing; (3) the cover-glass must be gently laid on—not pressed down; (4) the extracting of the hair must be performed very

* This has been noted by Sabouraud only in his most recent work.

gently and in the direction of the axis of its growth, so as, if possible, to obtain the soft bulb intact. It is also of importance not to disturb the hair by moving it from a watch-glass to a slide after soaking in potash solution or by warming it, as the hair-bulb so easily breaks off when the hair has become softened.

The hair may be placed in ether before mounting in liquor potassæ. This helps to clear it, and also prevents the softening action of the liquor potassæ, but, as a rule, it is unnecessary, except when the hair carries a great deal of fat and scale, *e.g.*, when the scalp has been covered with pomade or when seborrhœa coexists.

A word may here be said on the subject of staining the parasite. The method which has yielded the most satisfactory results is that of Gram, but it is open to the same objections as all other staining methods, that it does not permit the relation of the fungus to the hair to be accurately defined. The hair is comparable to a thick "section" in which several layers of the fungus elements are present, and, moreover, the fungus is so dense, and takes on the stain so abundantly, that a more or less opaque specimen is obtained.

THE SMALL-SPORED VARIETY (*MICROSPORON AUDOUINI* OF GRUBY).

The ordinary type of ringworm met with in hospital practice in London appears to be due to this form, for among 178 such cases 173 showed the small-spored parasite. This exhibits a far greater predominance of the small-spored form than is found in Sabouraud's statistics, in which the numbers of small and large-spored cases were much more nearly equal (12-8).

The *clinical appearances* correspond closely with those detailed by Sabouraud. In typical and advanced cases there are numerous and various sized, well-defined, circular patches scattered over the whole scalp, or one or two large patches with outlying smaller ones. The patches are not bald, but thickly covered with stumps of about one-eighth of an inch in length, each stump being surrounded at its base by a whitish sheath. Among the shorter hairs are scattered isolated and small groups of long normal hairs. The hairs, when not disturbed by rubbing, all lie in one direction. They are pale and lustreless as compared with the normal hairs, and have lost their

elasticity, as can be demonstrated by rubbing a patch, when the hairs remain standing in opposite directions instead of returning to their original position. On pinching up the stumps between the finger and thumb they can be easily extracted in bundles, generally breaking off in the follicle, but occasionally one or two bringing with them the soft bulb. The patch may be scaly, or not, according as the scalp is washed or neglected, but there is no marked alteration in the appearance of the skin itself unless complicated by seborrhoea. Sometimes the mouth of the follicle is a little raised above the surrounding surface, giving the appearance of "goose-skin"; and where scaling is present the skin beneath may be found reddened on removal of the scales. In other cases the patches are less well-defined, and the short diseased hairs appear diffusely scattered among the longer healthy ones, sometimes over the greater part of the scalp.

The appearance of the disease in its earliest stage is that of a scaly patch about the size of a threepenny piece, over which only a limited number of the hairs are broken off. Subsequently, as the remaining hairs on the patch are involved, they break off.

Other cases present bald or almost bald patches, and in these there is always a history of inflammation or "humour" and "scabs" as the mothers describe it, *i.e.*, of a previous "Kerion" condition.*

In many instances the actual kerion existed at the time of examination. This is distinctly contrary to Sabouraud's views, who states that kerion never occurs in the small-spored type, but is always due to the presence of the large-spored *trichophyton ectothrix*, identical with that which causes ringworm of the beard. In this series of cases, however, there were ten in which kerion existed, or in which there was evidence of previous kerion, as shown by the history and presence of smooth bald patches. In each of these a history of a non-inflammatory period previous to the kerion could be obtained. In two of these cases, also, a child in the same family was affected at the time with the ordinary small-spored type without kerion condition.

In thirty-nine cases there existed at one time or another lesions on

* None of the cases observed corresponded to the type described by Living and other observers in this country as "bald ringworm," in which the hair falls without antecedent inflammation, causing the production of patches similar to alopecia areata. These are probably always the result of a large-spored *endothrix* form.

the body or elsewhere than on the scalp, either in the patients themselves or in the mother, or attendant of the patient.

The usual lesions were small scaly patches, varying in size from one-eighth of an inch to about one-third of an inch in diameter. They were generally situated on the face or neck, or about the shoulders. In the latter situation they were sometimes very numerous, perhaps having taken their origin from hairs and scales falling from the scalp.

In addition to these there were cases in which the body lesion consisted of a well-marked, red, raised ring, generally about three-quarters of an inch in diameter, but frequently much larger. In four families the mother or attendant had such a ring upon the arm or wrist.

The earliest lesions on the scalp are those mentioned above as small scaly patches. These correspond exactly in appearance with the lesions found upon the body, and, as will be seen, *the fungus at this stage is confined to the epithelial scales, as in the body lesions.* It is only after the scaly patch has reached the size of one-third of an inch or so in diameter that the hair is invaded. From this time the hairs begin to break off and the patch gradually enlarges until the typical stump-covered areas are produced.

In like manner, in those cases where the body lesions had passed beyond the small scaly patch stage, the glabrous hairs were found to be attacked by the parasite in the same manner as the hairs of the scalp.

MICROSCOPIC APPEARANCES of the small-spored form (*Microsporon Audouini*). Hairs extracted and mounted with the precautions previously described present the following appearances:—The whole root-stem of the hair is surrounded by a sheath of closely placed small spores, extending from a short distance above the intrafollicular portion to the junction of the root-stem with the soft root-bulb (Fig. 1). That the spores do form a sheath, and that they do not infiltrate the hair, is easily demonstrated in a specimen cleared by liq. potassæ and uninjured by pressure of the cover-glass. The layers of spores on opposite surfaces of the hair and the intermediate hair free from spores, can each be focussed separately. On the bulb itself are strings of spores, radiating from the papillary centre towards the root-stem (Figs. 2 and 7). The strings are single, or in

groups of two or more rows side by side. They are clearly seen to be on the surface of the bulb and not in its interior. It seems possible that the strings of spores upon the root-bulb are not present while the hair is *in situ*, but that they are deposited there during the process of extracting the hair. When a hair is sometimes extracted with the epithelium of the follicular wall attached and covering the spore-sheath, the strings of spores are not seen upon the bulb. It would seem, therefore, that they may possibly be picked up by the expanded soft bulb as it passes through the follicle, upon whose walls some portion of the spore-sheath may still remain.

There is no mycelium on or in the bulb, but at the neck of the bulb, just at its junction with the root-stem, there is a fringe of mycelium, surrounding the hair and projecting below the lower margin of the sheath of spores around the root-stem (Figs. 2, 3 and 8). By careful focussing it can be seen that the mycelium extends upwards beneath the sheath of spores to form an internal sheath between it and the hair. The mycelium is most abundant at the lower part of the root-stem, becoming more broken and scanty as the aërial portion of the hair is reached. The spore-sheath passes a little way on to the aërial stem as described by Sabouraud. Above this there are scattered spores and broken rods of mycelium, the latter lying parallel with the hair-shaft. In the aërial stem there usually exist one or more cross fractures of the hair. At this stage the cuticle of the hair is destroyed throughout its whole length, and the mycelium appears imbedded in the surface of the hair.

If now the cover-glass be pressed down, the specimen becomes spread out and the elements of the fungus—the mycelium and spores—can be more carefully studied. The mycelium consists of a network of transparent threads about the same width as the spores, *i.e.*, two micro-millimeters. The threads lie in a direction parallel to the long axis of the hair, and can be seen occasionally to branch in a downward direction (Figs. 2, 3 and 8). Under a higher power ($\frac{1}{1}$ oil immersion) it is seen that the mycelium is divided into long segments, each division containing one or more darker spots. The spores are almost uniform in size, varying only from 2μ to 8μ in diameter; they are circular, opalescent, and have a double contour.

If, instead of using a weak solution of liquor potassæ, one uses a 40 per cent. solution, as advised by Sabouraud, quite different results

are obtained. The mycelium is then with difficulty made out. That this is not due to any dissolving action of the liquor potassæ is shown by the fact that on washing away the strong solution with water the mycelium becomes quite distinct. Again, if, as Sabouraud does, one warms the 40 per cent. potash solution, the hair bulb is destroyed, and this portion of the specimen is lost. These points are repeated because Sabouraud at first denied the existence of mycelium in the small-spored variety, and in his latest paper states that, though present, it is only with difficulty made out by an elaborate method of preparation which breaks up the hair and destroys the true relations of the mycelium with the hair itself. In specimens obtained by ordinary epilation, *i.e.*, without especial care to extract the soft bulb, one sees (Fig. 4) the aërial portion with cross fractures, denuded of its cuticle and having on its surface the broken rods of mycelium and the follicular portion surrounded by a dense sheath of small spores and broken raggedly at its lower extremity, but one misses the "fringe" of mycelium, since the hair is broken always above the neck of the soft bulb.

In a large number of these "small-spored" cases, in addition to the typical fungus, there are spores and mycelium of quite different appearance and of much larger dimensions. These elements are much less abundant than the "small-spored" elements. They are usually seen as thinly scattered groups or isolated chains on the surface of the shaft at about the junction of the follicular with the aërial shaft, and sometimes as chains of large-jointed mycelium nearer the root. The elements are quite different in appearance from those of the main fungus. They are somewhat irregular in outline, and refract light only slightly, so that they present a faint ghost-like appearance (Fig. 9). Their possible significance will be referred to below in describing the hair at an early stage of attack.

In specimens obtained from the early scaly patches of the scalp before the hairs become broken, the earliest invasion by the fungus can be studied.

As already stated, these early patches resemble the small patches seen upon glabrous parts in this form of ringworm, and contain a network of fine mycelium, as do these latter lesions. Neither in the scales from the early scalp-patches nor in those of the body lesions are any spores discoverable. In many of the hairs abstracted

from an early patch nothing abnormal can be seen, but here and there a hair is found with its cuticular covering intact but invaded by mycelium. The mycelium can be seen piercing the cuticular covering from the outside at the upper part of the follicular shaft, and passing downwards as long wavy threads towards the root (Fig. 5). It lies immediately beneath the cuticle and terminates as a fringe just at the neck of the soft bulb (Fig. 10). Concerning the manner of origin of the spores forming the sheath in a completely invaded hair I have been unable to satisfy myself, though the presence of the larger elements above alluded to seems to suggest an explanation. In many of these early hairs there are no spores discoverable, but in others there is a more or less imperfect sheath of small spores, and in these the larger elements are always present. These latter exist as groups and short chains at the upper part of the surface of the follicular shaft, and when traced downwards they are seen to become smaller and smaller, passing gradually into the typical small spores of the sheath (Fig. 6) ; on the other hand, intermediate stages can be traced between the slender mycelium of the scales and these larger joints. It would thus appear possible that the larger spores are the elements from which the spore-sheath takes its origin.

(To be continued.)

SOCIETY INTELLIGENCE.

DERMATOLOGICAL SOCIETY OF LONDON.

At the Ordinary Meeting of the Society, held on Wednesday, June 12th,

Dr. CAVAFY showed the case of a carman, æt. 36, affected for four weeks with a polymorphic eruption of the skin, accompanied by much itching and smarting. The eruption first showed itself on the face and ears, and gradually assumed its present extent. There are now still a few lesions on the face and ears, but the eruption is far more copious on the trunk and upper and lower extremities, especially the thighs; the penis and scrotum are free. The lesions consist of (a) papules about the size of a hempseed; (b) raised, dull pink, flattened, erythematous patches, with rounded irregular outlines, of which the largest does not exceed a crown-piece in diameter; (c) small bullæ about the size of large and small peas, very tense and hard to the touch, containing a citrine or pale sherry-coloured fluid, and mostly seated on normal skin, rarely on the erythematous patches; (d) thin crusts, of a brownish or blackish-purple tint, corresponding in size to the bullæ, and doubtless caused by their drying up; (e) a few scratch-marks, and lacerated papules with adherent blood-crusts are also present. The above-described lesions, more especially the bullæ, occur in small clusters of two or three together, the erythematous patches giving rise to small gyrate figures by confluence.

The patient states that the affection is decreasing in severity, and apparently tending to spontaneous subsidence. Although, therefore, the character of the lesions, their multiformity and aggregation agree with the *Dermatitis herpetiformis* of Duhring, the fact that we are not yet able to say that it will become chronic, with frequent exacerbations, and that it seems to be running a favourable course, render it preferable to refer it to some form of *Hydroa* (perhaps the acute hydroa of Unna) as a provisional diagnosis.

Dr. COLCOTT Fox demonstrated (1) a case of *Mycosis fungoides* in a man aged 49. The patient was exhibited last year to the Medical Society of London, and the history of the case will be found in the *Transactions* of that Society for 1894 (vol. xvii.). The duration of the disease has been about nine years. The first symptom was an eruption on the chest of indeterminate nature, and this was followed by a generalized eruption of "eczema." These superficial patches of "eczema," dry and scaly, or weeping and crusted, have evolved ever since over various parts of the head, trunk, and limbs. Many of them are indistinguishable from chronic eczema, but others are distinctly more infiltrated, and of a peculiar brownish-red colour. The first tumour appeared about two years after the commencement of the eruptions, and the second soon after. These two, the one on the forearm and the other on the loin, are still present, extensive, ulcerated and fungating. There are now many other tumours in evidence on the scalp, face, trunk and limbs, of various sizes, some smooth and unbroken and of a brownish-red colour, others crusted, and all very solid to the touch.

The patient does not complain now of pain or irritation. His health has distinctly deteriorated, but the man's health is not yet feeble. Several tumours have undergone spontaneous resolution. Altogether the case is a very typical one.

Dr. Fox exhibited a portrait of another case lately in the Westminster Hospital under the care of Dr. de Havilland Hall, and about to be published in the *Clinical Society's Transactions*. In this case there was wonderfully little eruption as distinguished from the tumours, and growths existed in the larynx. A third case, previously published by Dr. Fox, had, on the other hand, very few tumours, and the body was universally affected with an eczematoid eruption.

Dr. COLCOTT Fox exhibited (2) an infant with a copious eruption of small black-headed Comedones situated around the neck and upper part of the chest and back. A few extended upwards behind the ears, and others were placed symmetrically over the deltoids and shoulder-joints. Mixed with the comedones were a proportion of acne pustules forming secondarily from the comedones. The mother stated that this eruption had existed for twelve months, but that the acne pustules disappeared in the winter. Dr. Fox showed a drawing of a

somewhat similar condition on the back of an infant, but in this case the eruption was more inflamed and confluent. He regarded this eruption as belonging to the same category as the comedones of the foreheads of young children, which was of far more frequent occurrence, and which had been described by Drs. Crocker, Cæsar, and the exhibitor.

Dr. COLCOTT FOX brought forward (8) *an infant with Erythema multiforme* of an unusual kind. Without any obvious constitutional symptoms the child had developed, five days previously, on the thigh a nodule of erythema nodosum. Since then isolated nodules had continued to evolve bilaterally on the outsides of the buttocks and thighs. The nodules involved all the layers of the skin, were red, the size of a hazel-nut, and were not very tender to the touch, in contrast to those usually met with on the skins of old children. A further peculiarity was the excentric spread of the lesions. The ring form was rapidly lost, and a broad crescent left of so-called erythema marginatum, and finally much pigmentation. No drugs had been administered to the child previously.

Mr. MALCOLM MORRIS showed (1) a case of *Keratosis pilaris* in a boy of 5. The upper arms (especially on the outer aspect) are very rough to the hand, and present a number of fine, small spiny processes. The palms of the hands are rough, and the lines are well-marked. The thighs also present a similar spiny condition, and the whole skin, including the scalp, is everywhere dry and harsh to the touch. The condition was first noticed about two years ago. There is no history of any similar condition in the family. The hair and teeth are normal, and he is well in himself.

Mr. MALCOLM MORRIS also showed (2) microscopic specimens from the skin of a so-called "elastic-skin" man stained by Unna's orcein method.

Dr. PENROSE brought forward a boy, aged 7 years, recovering from an extensive *bullous Eruption*, which began on May 18th, with groups of closely-aggregated vesicles the size of a pin's-head on the sides of the fingers of the right hand, and appeared the following day on the sides of the toes of the left foot. Fresh lesions in the form of larger vesicles and bullæ appeared later on the limbs and trunk.

The eruption was unattended by pain or itching, and the child appeared to be in good general health.

When admitted to Great Ormond Street Hospital, on May 27th, it was noted that his hands and feet were studded with lesions indistinguishable from *Pompholyx*. Circular patches of erythema, varying in size from a threepenny-piece to a half-crown, many coalescing and looking like old bullæ, were present over the face, neck, trunk, extensor surface of arms, forearms and hands, as well as over the fronts of the thighs, the knees and dorsa of the feet, while several recent blebs were present over the lower part of the abdomen. The temperature was slightly elevated (99° Fahr.), and the tongue coated.

A few days later (May 31st) the temperature rose to 102° Fahr., and the child was in great pain and very ill; the bullous eruption, which had extended by crops, was present over its former sites in greater intensity. The back of the trunk and the palms and soles were, however, free. The contents of the bullæ were for the most part clear, but some were purulent. Capillary pulsation was visible in the reddened bases of many of the ruptured blebs. The mucous membranes were unaffected.

The child gradually recovered, no fresh bullæ developing after June 7th. The treatment consisted of the administration of Liq. arsenici hydrochlorici, min. ij., combined with Quinine, gr. ij. three times daily throughout, and when the eruption was at its height, of prolonged immersion in a boracic bath at 90° Fahr.

The case was exhibited on account of (1) its appearance in the first instance as a *Pompholyx*; (2) of the severity of the general symptoms; and (3), of the rapid improvement under treatment. It was considered by the exhibitor as a case of *Pompholyx*, with a superadded attack of acute *Pemphigus*, but many members of the Society thought it an *Erythema multifforme*, and others a *Dermatitis herpetiformis*.

Dr. PERRY exhibited the case of a young woman, Emily P., æt. 20 years, whose skin was universally red and desquamating, the desquamation being of a branny and powdery character. In the view of the exhibitor the disease from which she suffered was *Pityriasis rubra* in a mild form, and in his opinion several members of the Society coincided, others holding that the case was really one of xerodermia,

with inflammatory reddening of the cuticle. Much, therefore, depended upon the history, and though the witness of the mother was available, it was not easy to arrive at the facts. It appeared, however, that as a child her mother found it very difficult to keep her daughter's hands clean. Beyond this there was no evidence that the skin had been other than healthy. The present condition began three years ago, with "scurvy" starting at the back of the neck, and extending to the waist. For the last two-and-a-half years the redness of the skin and scalliness have been universal. Rather less than three years ago the patient was working in a factory, when the skin disease upon the arms attracted attention, and she was dismissed upon the ground that she had "something catching," though a doctor whom she then consulted gave her a certificate that she had eczema. There is "no skin disease in the family."

The patient states that as a rule her skin does not itch, but it feels drawn and tight, and sometimes burns, especially after washing. All parts are about equally affected, though on the whole the flexor surfaces are less scaly than the extensors. The palms and nails of the hands and feet are normal, and there is free perspiration in those situations. The exhibitor has seen the patient since she was shown to the Society, and her condition remains unaltered after daily application of ung. diachyli, the skin being as red as when she first came under notice.

Dr. J. J. PRINGLE brought forward (1) a well-marked example of *Urticaria pigmentosa* in a boy one year of age. The disease was first noticed at the age of three months, when, according to the mother's statement, brown spots, similar to those present, first made their appearance upon the buttocks and back. They continued to appear till the child was nine months of age, since when they have been stationary. The child was plump and well-nourished, of peculiarly happy temperament, and with no family history or detectable dietetic errors calculated to throw any light upon the etiology of the affection.

The lesions consisted of dark brown, slightly raised papules, or small tubercles, averaging about the size of a split-pea, although mostly more oval than circular in outline, moderately firm to the touch, not arranged in groups nor with any marked symmetry, although very

numerous and practically universal in distribution, the only part unaffected being the face. They were most thickly distributed over the gluteal regions and adjacent parts of the thighs and loins. They were present in considerable numbers on the palms and soles and scalp, in all of which situations they showed themselves as dark-brown macules not raised above the general skin level, and unaltered by pressure. There was obviously *no itching*, and the child had never been known to scratch. Factitious urticaria was, however, present, and after rubbing them with the finger the lesions were, as it were, "lit up," becoming pinkish, raised, and somewhat wheal-like; these appearances were, however, very evanescent. The mucous membranes were unaffected and the urine healthy.

Dr. PRINGLE also showed (2) sections of a case of *Pityriasis rubra pilaris* of Devergie from a patient under the care of Dr. Liddell of Harrogate.

Dr. RADCLIFFE-CROCKER showed (1) a case of *Acquired Ichthyosis* in a man of 74. The patient, who was an educated man, stated that up to ten years ago he sweated freely on exertion, but since then his skin had been gradually getting drier and assuming its present condition, which had developed much more rapidly in the course of the last year. He had undergone no privation and had fairly good health, except that the bowels were habitually loose—sometimes to the extent of four or five motions a day.

The skin presented exactly the aspect of a congenital ichthyosis. This was especially well-marked on the lower extremities, and was more pronounced on the left than the right limb. On the dorsum of the left foot the scales were in parallel rows from the toes upwards, but above the ankle they were no longer separate, but formed an epidermic crust of nearly uniform thickness, broken up by transverse and vertical furrows in the usual ichthyotic fashion. The soles were much thickened.

The condition was less pronounced above the knee, but the scales were still large; above the buttocks they were more of a branny character all over the trunk except the abdomen, where they were again conspicuous. On the extensor aspect of the upper limbs the scales were also larger and presented the typical characters of a mild ichthyosis. The face was only dry and slightly rough. Unlike

marked cases of congenital ichthyosis, the lobes of the ears were long and of good shape.

Some of the members objected to any condition being called Ichthyosis which was not of congenital origin, but the presenter defended the title "Acquired Ichthyosis" because it was in established use, and, clinically, the appearances were exactly the same whether the skin was deprived of its natural lubrication by the congenital absence of the sweat and sebaceous secretions, or by the wasting of the glands subsequently.

Dr. RADCLIFFE-CROCKER also showed (2) a case for *Diagnosis*. The patient was a goods porter, æt. 35. The disease had been present more or less for eight years, during which time he had never been quite free. It did not appear to be influenced by the weather or the time of year, but was brought out by getting heated in his work, and a glass of beer would bring it out freely. It always came out in the same way and with the same distribution. The latter was as follows:—Symmetrically on the lower part of the trunk below the nipple, the chest above this being free; in and about the axillæ; the root of the neck; the point of the shoulders; and on the inner surface of the arms as far as the elbows. Posteriorly it was almost all over the back except in the vertebral groove and over the inner half of the scapulæ. It only affected the sides of the buttocks and ceased there, with the exception of a patch in each popliteal space. In front the groins were involved.

The lesions consisted of pin's-head to millet-seed vesico-pustules, flatly convex on a slightly elevated red base, with a tendency to form irregular groups of three to five. The eruption was attended with slight burning but not itching, and in two or three days the fluid dried into a superficial crust, which was thrown off in a few days more, leaving a red stain. A fresh outbreak occurred every few days when he was at work. The question was whether the case was to be referred to *Hydroa herpetiforme*, against which were its uniform characters and absence of itching, or whether it was a *benign form of Impetigo herpetiformis*, or, again, whether it was a serial eruption analogous to the miliaria often seen in infants. The exhibitor, on the whole, inclined to this last view, so that it might be considered as a *Miliaria pustulosa*.

Dr. SAMUEL WEST sent a boy, aged 7 years, suffering from *Comedones* of the forehead and anterior half of the scalp, of about six months' duration. Many of them were suppurating. There was no history of contagion, and the patient was the only member of the family affected.

THE DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND
IRELAND.

THE Annual Meeting and Congress of this Society was held on Thursday, May 30th, 1895, the President, Dr Pye-Smith, F.R.S., in the Chair.

The President, in delivering his opening address, said:—

GENTLEMEN,—In cultivating the department of medicine to which our Society is devoted, our first and most essential duty is, it appears to me, to advance our knowledge of the Pathology of the skin, the natural history of its diseases, and discrimination between them; and with this object to keep in close connection with the broad and ever-flowing stream of General Pathology. Unless pursued by scientific methods and on pathological principles, Dermatology would again become, what it once was, little better than a trade in cosmetics.

While, however, Pathology and Diagnosis are the chief objects of our care, we do not forget what, to the public (and to the less intelligent part of our profession) is the only object of medicine, the direct cure of disease. The paper to which we are looking forward from Dr. Crocker is therapeutical in subject, and in these few introductory remarks I would draw attention to some points in the treatment of diseases of the skin.

It has often been said, and justly, that English Dermatologists in past times paid too much attention to internal treatment. They were too apt to assume, first, that cutaneous disorders were due to some "constitutional" cause; and, secondly, that they could ascertain what this cause was. True, rational treatment must depend on knowledge of ætiology; but this is the most difficult branch of medicine; and therapeutics based on sound experience is far more efficient than when it follows arbitrary assumptions as to causes. Myself a disciple of Hebra, I hold with him that while "constitu-

tional" remedies have an important place in the treatment of diseases of the skin, they are in most cases subsidiary to local applications, and that treatment in this, as in other branches of medicine, should be empirical rather than deductive.

The *internal treatment* of dermatoses includes two distinct methods: first, what may be called physiological, the use of purgatives, diuretics, sedatives, and other drugs, the value of which depends on their indirect action on the skin; and, secondly, drugs like arsenic and mercury, which directly and immediately modify the nutrition of the skin after they are taken into the circulation. The latter remedies, let us remember, though general in their application, are special and local in their effect. In the case of psoriasis cured by the internal administration of arsenic, or a syphilide by mercury, the drug, though administered by way of the circulation, is only efficient when it reaches the skin, and therefore, in one sense, these remedies may be called local.

Of all the internal physiological drugs at our disposal there are few more efficient than "the element," as it used to be called, which forms the vehicle or excipient of most of our prescriptions. To apply Hesiod's apothegm τὸ ὕδωρ ἀριστον, water is in many cases the best remedy. Many forms of general disease, and not a few dermatoses, are more or less due to want of a proper amount of water internally—almost as many as those which depend upon too large an admixture of other liquids. The chief difficulties in the administration of the remedy in question are the amplitude of the dose and the frequency of the administration needful to produce its full effects. But when judiciously taken in half-pint doses as a laxative in the morning, as a sedative at night, as a diuretic, with a cool skin, or a diaphoretic when the skin is warm, as an expectorant, or a refrigerant, its value is remarkable.

Two examples may serve to show its importance in cutaneous medicine. One is the high estimation in which were formerly held the "tisanes" of French medicine and the weak infusions and "waters" so generally used in the treatment of eruptions until recent times in England. Infusions of cascarilla, serpentary and chamomile; cinnamon waters and camphor waters were rightly prescribed, not by tablespoonfuls but by pints; and although I have no doubt that in some of these cases we lose the help of valuable drugs because we give

them in too small and concentrated doses, yet probably a large share of the benefit of such dilute but abundant medicinal draughts was due not to the simple but to the vehicle that conveyed it.

The other example is the undoubted benefit in the treatment of many cutaneous as well as other maladies which is obtained by drinking mineral waters. No one here will believe that it makes any difference whether sulphates are taken in mineral waters at Epsom, or Cheltenham, or Karlsbad, or dissolved in water by a druggist and sold in eight-ounce bottles. The contrary superstition would be as absurd as to suppose that it makes any difference in the effect of a warm bath upon the skin whether it comes out of the earth at a given temperature or is raised to the same degree in a kitchen-boiler. But it does make a great difference whether alkalies and salines are taken in large concentrated and infrequent doses or in very small, very dilute, and very frequently repeated ones; and it makes a great difference whether a patient is ordered, in addition to his ordinary diet, to take three fluid ounces of water three times a day, or whether the dose be pints and quarts. Considering the real efficiency of water as a drug, it is perhaps surprising that the system of quackery introduced by Priessnitz has not spread wider, and so done more mischief than the system of quackery introduced by Hahnemann.

As just remarked, the administration of arsenic and mercury is really a local application of these drugs to the skin or other organ diseased; but we are sometimes apt to forget that it is also an application to the organs which are not diseased. When mercury is conveyed by the circulation to the diseased tissues of the skin it is also conveyed to the intestine, and acts (probably indirectly) upon the liver when reached. When arsenic is conveyed by the circulation to the skin in psoriasis it also visits the digestive organs, the blood-forming organs, the heart, and the joints just as much as when we give it in cases of anorexia, of idiopathic anæmia, or of osteo-arthritis. A complete account of the therapeutical action of the drug must include its action on every organ and in every form of disease.

Turning to what are commonly called local remedies, in those which are locally applied, and therefore affect local changes only—we all admit the efficiency of local astringents, rubefacients, stimulants, caustics, or anodynes; but for them thus to act upon the living epithelial cells and corpuscles of

the connective tissue, or the papillary blood-vessels, the touch-corpuscles, cutaneous nerves, and muscular apparatus of the hair-sacs, they must either be absorbed through the dead horny layer of the epidermis by inunction, or they must gain access directly in aqueous solution to the living tissues when already denuded of their protecting cuticle. It is in this way that salts of lead affect the vessels, that belladonna influences the sweat-glands, and anodynes the cutaneous nerves. A lotion on a whole skin runs off almost like water from a duck's back, and an ointment spread over a patch of weeping eczema never gets nearer the disease than the surface of the watery film on which it floats. Other remedies, however, those which are called ceratolytic, act, not vitally, but chemically and directly, upon the horny layer of epidermis. Others again, as sulphur, mercury, phenol and boric acid, exert a destructive power, not on the skin itself, but on animal or vegetable invaders.

There are, however, other most valuable local applications which have no such active and special properties. In fact they are chemically and physiologically inert, and yet are therapeutically useful. They act by supplying lack of sebaceous secretion, or by protecting the skin from the irritation of sweat, or urine, or of dust, or cold, or heat, or even from the mere access of air at ordinary temperatures. We all know how important it is in applying local remedies to the skin to decide whether they shall be conveyed in the form of powder, or as an ointment, or in aqueous, alcoholic or ethereal solution; and surely it is probable that the important difference of action which depends on the vehicle chosen will apply to the unmedicated vehicle itself. Merely covering an inflamed surface with an inert powder like starch is, we know, of great value in erysipelas and some forms of erythema and eczema; and probably similar applications of zinc, bismuth and other chemical compounds differ rather by their physical than their physiological properties. So, also, it is sometimes more important whether we choose benzoated lard, or wax and oil, or soft paraffin or lanolin for the vehicles of our ointments than whether we put this or that drug in the vehicle. We not infrequently meet with cases of Dermatitis which may be properly described as *Noli me tangere*, for any local medication seems at once to aggravate the condition, and the only efficient treatment is to guard them sedulously from every kind of mechanical or chemical disturbance.

Again, we are reminded, in the treatment of diseases of the skin, of that most important principle of number and weight and dilution—time and circumstances of administration—frequency and duration, which so greatly complicates the study of general therapeutics. No one doubts the purgative power of magnesian sulphate, but how much is this increased when taken in a copious draught of warm water on an empty stomach, whereas the same dose, less diluted and taken after a meal, will act as a diuretic. Opium in small doses is a stimulant, and rather increases than assuages pruritus, so that in cutaneous medicine we are fain to seek almost any other sedative. How different is it with chloroform, chloral, menthol and ice. Again, what contrast there is between the effect of tar ointment and that of dilute solutions of empyreumatic compounds.

No more striking example of this difference can be adduced than the external action of water. On the perfectly healthy skin, protected by the horny cuticle and rendered impervious by sebaceous secretion, frequent and prolonged immersion produces no effect, but when the resisting power of the tissues is diminished—when, from causes for the most part unknown, the cutaneous equilibrium becomes unstable—then there is no more potent irritant than the frequent application of water. Evaporation seems to be a principal cause of this result, for in cases of eczema which are obviously aggravated by washing we may apply water dressings to the part, or may even keep the patient in a continuous bath for hours and days with the result of soothing instead of increasing the inflammation.

With respect to the doses of internal medicines, it is a curious and not merely speculative question whether, in the case of patients who, not from fancy or whim, but as a proved objective fact, are unable to take ordinary doses of certain drugs, we may assume that, their physiological action being so strong, their practical effect will be equally pronounced if given in a very small dose, or whether we must in such cases conclude that for some reason the patient and the drug are mutually incompatible, and that our only prudent course is to give it up entirely. I used to believe the former, but of late, I am sorry to say, I incline to the latter opinion.

The question of the best mode of administration of a drug finds nowhere a better example than in the case of mercury. There can be little doubt that in whatever form exhibited, all mercurial prepara-

tions reach the tissues in the same condition of a soluble albuminous compound; but the methods of introduction of the drug into the circulation are numerous, and their relative advantages and drawbacks various.

Do the subsalts differ from the persalts in ultimate action? What cases are best adapted for the exhibition of blue-pill, of calomel, of grey powder, of Plummer's pill, of mercuric iodide, or of corrosive sublimate? What are the relative advantages of inunction, fumigation and subcutaneous injection? Why has practice at different times, in different countries, and in the hands of different practitioners, varied so greatly? And why has the costly, painful, and tedious (one had almost said indecent) method of intramuscular injection of solution of mercuric chloride become almost universal in some countries, while it is only used in exceptional cases here?

One cannot speak of cutaneous therapeutics without some allusion to the question of *meat and drink*, particularly with the modern meaning of the two words as denoting animal food and alcoholic beverages.

There can be no doubt that in cutaneous medicine, as in other departments, "dieting" has been carried to an extreme and often a ridiculous minuteness. For most of our patients excessive quantity of food and imperfect mastication are much more important causes of illness than special quality. What most people eat is for most people wholesome, and what a natural appetite finds appetizing seldom disagrees.

On most forms of cutaneous disease I believe diet has scarcely any effect. But there are exceptions—some kinds of eczema are certainly better for restriction of animal diet; pruritus is usually increased by spiced and peppered dishes, and most of the true erythemata, including urticaria, are sometimes caused and almost always aggravated by certain articles of food, not always the same, and not always productive of other symptoms of dyspepsia besides the erythema. In fact, one of the distinctive characters of the group of erythematous affections, including urticaria, gutta rosea, and most rashes caused by drugs, is that they depend not on external but internal irritants.

Another affection, acne, is undoubtedly greatly influenced by food, not in every case, nor to an equal degree. In some patients a fresh

outbreak of follicular inflammation can be produced at will by eating "crystallized" fruits, strawberry jam, or orange marmalade.

With respect to drink, water drunk freely between meals is an excellent diuretic, and seems to benefit most superficial forms of dermatitis, and the infusion of lemon with cream of tartar, known as imperial drink, is an admirable refrigerant laxative, diuretic, and sedative.

Eczema, when very irritable, and most forms of inflammation of the skin (as of other organs) in the early stage are believed, and, I think, with good ground, to be aggravated by alcoholic beverages of any kind. But in chronic forms of eczema, in psoriasis, and most other dermatoses, I am not aware of any reason for prohibiting such amount and kind of wine or malt liquor as on other considerations are found to agree with the patient; and I am sure that in many cases of recurrent subacute erythema with anæmia, and in not a few of chronic eczema and of lupus, red wine taken with meals, and still more often porter, or, if this is not well borne, one of the lighter kinds of ale, is not only harmless but useful. For the marasmus we sometimes see along with general eczema in young children there is no drug so valuable as brandy, and I believe I have seen it "cure" as unmistakably as one can desire.

But I confess I do not understand why patients suffering from diseases of the skin are so frequently ordered to drink spirits-and-water. If alcohol in some form is indicated, and there are practical reasons against the use of wine or beer, by all means let us order it. But as a routine prescription I think it is most unadvisable. No doubt when a patient tells us his doctor "ordered" him to take whisky it often comes out on cross-examination that all that was ordered was abstention from other forms of liquor. But frequently we meet with young and otherwise healthy women whose mothers tell one with the pride of conscious virtue that their daughters drink nothing but whisky-and-water. Why whisky is thought more wholesome than brandy, and Scotch whisky than Irish, I do not know. Some years ago rum was the fashionable spirit to recommend, and, so far as I know, beyond national partiality, there is no reason for advising one rather than the other. Brandy, hollands, whisky, or any other pure distilled spirit is invaluable as a medicine, and often most desirable for the insomnia of later life, or in the treatment of dyspepsia

or gout or chronic eczema in old people, but as a beverage for the young and healthy it is surely very seldom advisable. The contrast which Hogarth drew between Beer Street and Gin Alley is on the whole a true one, and should have weight with us as well as with moralists and statesmen.

There is another kind of diet which has already added to our store of therapeutical weapons, and promises to add still more. I mean the habitual injection of certain organs from the lower animals, which are believed to supply the defects produced by disease. We have probably all of us seen the harsh skin and coarse scanty hair of the disease well named by the late Sir William Gull "a cretinoid condition occurring in adults," at this time known as myxœdema, gradually change into the hue and aspect of health under the influence of thyroid tablets. The effect of some other similar food has proved less than was hoped; but in a case of Addison's disease, which I saw nearly two years ago, the patient has been greatly benefited if not cured by injection of suprarenals of the calf, prescribed for her by Dr. Oliver of Harrogate, under whose care she fortunately came, some time after consulting me. The only patient with this rare disease whom I have had since is a young woman with marked melasma, whom I have brought up to-day, and I hope I may see her colour fade under the same treatment.

Cutaneous therapeutics is an endless subject, and I must not trespass longer upon your time.

To conclude my address with what preachers call an application, I would urge the importance in the therapeutics of the skin, of not forgetting the other organs which our remedies affect, of making the application of local remedies as constant and efficient as possible, and of considering as not less important than the choice of the drug, whether external or internal, which we use, the method in which it is applied, the strength, the duration, and the frequency of the application. As Hebra long ago said of eczema: "He will obtain the best success in treatment who is not always changing his methods, but persists in the use of whatever plan is indicated with patience and determination."

Dr. LIVING proposed a vote of thanks to the President for his address, and remarked that its suggestive and practical character made it unusually welcome and instructive.

Dr. HARRISON (Clifton) seconded the resolution, which was carried unanimously.

The Senior Secretary (Dr. J. HERBERT STOWERS) read the report of the Council, which congratulated the Society upon the increase in number of its members during the past twelve months, and the interesting papers which had been read and cases exhibited at its meetings.

The Treasurer (Mr. Alfred Cooper) read his audited account, and stated that the financial position of the Society was very satisfactory.

After a lengthy discussion, the following resolution was unanimously passed, upon the proposition of Dr. Crocker, seconded by Dr. Savill, viz. : "That the day of meeting be altered from the second Thursday to the fourth Wednesday in the month."

It was also recommended that the Council be requested to consider whether additional meetings could be arranged beyond the number specified in the Society's laws.

Dr. H. RADCLIFFE-CROCKER read a paper entitled "The Internal Therapeutics of Psoriasis and some other Diseases of the Skin."

He felt that the progress made in the internal treatment of diseases of the skin had not advanced in the same way as had the external methods, and he feared that the success of local applications had the effect of throwing internal therapeutics into the shade, and that there was a tendency to regard them as little better than relics of a bygone age. However, the introduction of tuberculin and of thyroïdin had revived the interest in internal remedies.

While admitting that the general health should be treated in all cases of skin disease, whether this appeared to have any bearing on the disease or not, he pointed out that we were so ignorant of the etiology and pathology of so many diseases that we cannot rely on any further lines of internal treatment with reasonable prospect of success.

Since psoriasis is a disease which usually occurs in healthy people, and there is no definite indication for internal treatment, the practitioner is likely to resort to empirical remedies, whether he understands their *modus operandi* or not. It was such refuges of "ignorance" that he wished specially to discuss.

Passing by minor claimants, such as antimony, turpentine, and iodide of potassium, he devoted himself to an old friend, arsenic; to a new friend, thyroid extract; and lastly, to a class of drugs which, though old acquaintances, he wished to introduce in their new capacity, namely, the treatment of psoriasis.

While referring to the utility of arsenic in those cases where

sufficient doses could be borne, and especially in the treatment of patches rebellious to local applications, he felt sure that, were the choice between arsenic and local remedies given to those who had much experience of psoriasis, they would unhesitatingly choose local remedies. He further stated that, although amongst the mass of the profession arsenic was given in every case of psoriasis or other chronic skin disease, there were undoubtedly cases in which it was not only useless but injurious: thus, in cases where the eruption develops acutely its use is very likely to produce extension of the disease, and in extremely hyperæmic cases its use appears to increase the irritation and burning of the affected parts.

Finally, as a prophylactic it fails entirely, since fresh patches arise while the patient is fully under the influence of the drug. In the ordinary run of cases, however, and in the absence of gastro-intestinal disturbance, its use was generally of service, but its action was very slow, and without local treatment cases would drag on for months; for chronic cases, also, it was useful in removing the last fragments. With regard to thyroid extract, Dr. Crocker stated that after a more continued trial, his experience tended to narrow the sphere of its usefulness, although he admitted its utility in a limited number of cases. He considered that the drug was unsuitable for elderly patients with weak hearts, on account of its depressing effects, and of the profound illness which was produced if the drug was not promptly stopped. He considered that it was also unsuitable in cases which were developing rapidly, or in which the hyperæmia was great.

In cases, however, which were not rapidly extending, or intensely inflammatory, and where the patient was organically sound, he considered that one might hope for success, but that thyroid treatment would only be an experiment, and a small dose should be given at first—not more than two five-grain tabloids a day, which dose might be increased to three or rarely four a day, but never more unless the patient was in bed and under observation. In some cases, which he had considered suitable, he had been disappointed.

In his experience thyroid extract did not give more permanent results than other treatment; thus, he had seen a lady who was suffering from a recurrent attack of psoriasis five months after treatment with thyroid extract by Dr. Bramwell. In this case thyroid

extract not only failed to relieve the patient but made the eruption come out more abundantly.

With regard to the last group of remedies, he was not aware that they had ever been regarded as having any influence on psoriasis or other skin diseases, and suggested that possibly many other drugs might be found to be valuable for the internal treatment of skin diseases, hitherto regarded as not amenable to drug administration. He wished to call attention to the use of salicin, salicylates, their allies and derivatives. The first case in which he gave salicylates was that of a man aged 32 years, in whom psoriasis had only existed for a month, and was first noticed two weeks after a quinsy, the tonsils being still swollen. The well-known association of tonsillitis and rheumatism induced him to give the patient salicylate of soda in fifteen-grain doses three times a day without any external treatment. After a week's treatment the patches became paler, and most of the scales had fallen off; within six weeks all was clear.

He also cited a case of Psoriasis guttata, which he had also treated with salicylates, and in which the eruption had almost completely disappeared without local treatment. In several other cases the result had been striking and conclusive, and most markedly so, in extensive spreading cases of Psoriasis guttata of recent development (the very forms of the disease usually unsuited both for thyroid extract and arsenic). The results were not so brilliant when the disease was limited to a few chronic patches.

When possible no local treatment was given at the same time, but often patients objected if they did not have any ointment given them to rub in, and so in some cases it was impossible to judge what share the salicylates had taken in curing the disease.

The first effect of the drug appears to be a diminution of hyperæmia, so that the patches become paler and the scales are formed less abundantly.

In only one case did the salicylate aggravate the disease, and this only occurred after increasing the dose to 25 grains; gastro-intestinal irritation, together with increase of the rash, followed, but on subsidence of the gastric trouble salicylates were continued, and were followed by improvement.

With regard to the drawbacks of the drug, he had found that a few patients were unable to continue salicylates, as it caused dyspepsia,

although it was always given after meals, so as to obviate any gastro-intestinal irritation as far as possible. In one case it produced nausea and occasional vomiting, but its use was not stopped; the substitution of potassium salicylate for the sodium salt caused worse nausea, but the patient was able to take salicin without discomfort, and the rash improved. He suggested that in such cases the pure natural salicin might be more easily tolerated.

Dr. Crocker had also given salicylate of soda, with considerable benefit in cases of Erythema multiforme (including Erythema iris), but as these diseases often naturally run a short course, it was difficult to have conclusive proof that the course of the malady was shortened by the drug, and was not due to spontaneous involution. In Erythema nodosum, also, its use was strongly indicated.

In one case of Lupus erythematosus, striking improvement followed the use of salicylates, although previous treatment by thyroid extract has been of no benefit; still Dr. Crocker had found that other cases of Lupus erythematosus had been benefited by both thyroid extract and arsenic, but he thought the use of salicylate was less likely to upset the patient than either of its two rivals. He had not been able to prove any benefit to arise from its use in cases of eczema. Finally, he mentioned that Arning claimed to have had good results in some cases of leprosy from salicylates, and Dr. Crocker would feel inclined to employ them, in the place of quinine, in a case with febrile exacerbations.

He then discussed how the salicylate of soda acted beneficially in these cases. He thought that, though its beneficial action in psoriasis might be considered to be a confirmation of the French view of the close relationship of this disease to "arthritis," no close etiological relationship was proved, because both affections were benefited by the same drug. He suggested rather that the result in both cases was due to the microbicide action of salicylate in the blood; evidence had been brought forward of the microbic origin of rheumatism, but the microbe of psoriasis was still hypothetical, and was possibly only one factor in the causation of the eruption; further, if the disease be admitted to be microbic, clinical facts pointed to the microbe's action from within the body rather than to its depositions *ab extra* on the skin. The microbe, too, must have periods of quiescence, from which it is awakened by various depressing conditions of body or mind.

Dr. Crocker concluded by asking the members of the Society to state their experience as to the indications and contraindications for arsenic and thyroid extract respectively, and as he believed that he was the first to publish good results in the treatment of psoriasis by the internal administration of salicylates, he summed up his conclusions on these drugs as follows:—

Salicylate of soda, and probably salicin and its derivatives, are of great value in psoriasis, especially in the period of active development and in hyperæmic cases which are unsuitable, as a rule, for arsenic and thyroid extract. They are useful in all forms except when they produce dyspepsia, and perhaps in old chronic patches. Finally, they are much less likely to upset the general health of the patient than either arsenic or thyroid extract.

The PRESIDENT thanked Dr. Crocker in the name of the Society for his address.

Dr. LIVING said he had no experience of the thyroid extract treatment, but with regard to arsenic he considered it by no means a satisfactory remedy, and most unsuitable to acute cases. Psoriasis was an uncertain ailment in relation to treatment, both internal and external, and at all times it was difficult to estimate the degree of benefit each could confer. With regard to salicylates, he had witnessed good results, but it was impossible to anticipate them. For acute cases he would rely upon salicylate of soda, or the iodide of potassium, or sodium. Attention to diet was most important in some cutaneous affections.

Dr. STEPHEN MACKENZIE considered that the careful observations which had been narrated was evidence of the improvement the salicylates were likely to produce. He had tried them with some disappointment in various forms of erythema, believing that some were of rheumatic origin; but this was not surprising, considering the similar disappointment frequently met with in the treatment of other diseases of known rheumatic origin. Psoriasis was frequently met with in rheumatic subjects, but rheumatism was a common disease. Phosphorus was a drug which had conspicuously failed to produce the results at one time attributed to it, owing to the manner in which it passed out of the body practically unaltered. He agreed, in the main, with Dr. Crocker's observations about arsenic, and considered it possible that recurrences of disease might be delayed and even averted by its administration, but the difficulty was to trace reliable effects to any one remedy. Thyroid extract, in his opinion, was to be used as a promising means when other treatment had failed.

Dr. BOWLES affirmed there was no room for doubt but that thyroid extract was as useful in the treatment of some cases of psoriasis as useless in others. It was possible this irregularity might depend upon a mixed cause, or the co-existence of two disorders or diseases in the same person; as, for example, a condition of myxœdematous origin, which, when removed by the thyroid extract, lessened the resistance of tissues to the effects of remedies, and even rendered structures unfavourable to the continuance of other diseases. This reason might explain

equally the good influence of the salicylates in psoriasis and its allies when commingled with the elements of gout rheumatism.

Dr. PAYNE said that the main difficulty was to estimate the proportion of benefit ascribable to the local and to the general remedy. Speaking without statistics, he considered arsenic useful in the treatment of psoriasis in children and in adolescents during early attacks, but of comparatively little use in persons at, or beyond middle age. His experience of the use of thyroid extract was limited and not encouraging. He expected more from iodide of potassium in large doses. Dr. Payne had already published his observations on the relative use of salicylate of sodium and quinine in cases of erythema, but he was not yet clear which was the more efficient. On the whole, there was no internal remedy to be compared to a good external one, if used at once.

Mr. WILLIAM ANDERSON had given thyroid extract in thirteen cases, seven of which were psoriasis, five lupus, and one lupus erythematosus.

In spite of admission into hospital and abstention from all local treatment, he confessed the results were either negative or unfavourable. In some the disease actually progressed, while in a few the temporary general disorder produced by moderate doses made them very ill. He was taught that arsenic was an accepted remedy, but personal observation had altered his conclusion; indeed its discontinuance had relieved patients from many disadvantages attributable to the drug when treated for psoriasis. He was satisfied, however, that in some cases, where an element of gout or rheumatism existed, the salicylates had produced decidedly beneficial results, but he needed more experience to justify his conclusions. Referring to the influence of diet he might say, when in charge of a Naval Hospital in Japan, he treated many patients for an endemic complaint called beri-beri, their custom being to eat more dried and salted fish than people of other countries in place of meat and rice. Subsequently his successor, by carrying out a reform of diet in the direction of fresh meat in reasonable amount, had the satisfaction of seeing startling improvements, some diseases almost entirely disappearing, while beri-beri was eradicated in the Navy. The value of this evidence was obvious. Psoriasis, of many years' standing, had, in his experience, disappeared with simple local treatment only, but a relapse had occurred, and he feared none of his remedies would avail.

Dr. H. G. BROOKE (Manchester) spoke of the inappropriateness in the treatment of psoriasis of arsenic as a routine medicine, and agreed largely with the observations of Dr. Payne.

He had not yet prescribed the salicylates, but would give them a trial. He had also to support the common experience in regard to thyroid extract, agreeing in the main with Mr. Anderson's observations. Dr. Crocker had stated that the thyroid treatment should be avoided in acute cases, and instanced leprosy.

Recently, however, he (the speaker) had treated a case of acute leprosy; other remedies failing, he prescribed thyroid extract, with very satisfactory results; but this was the only instance of the kind in his experience. On several occasions he had been enabled to remove one or two initial lesions of psoriasis by the simple application of plasters.

Dr. ABRAHAM said he was glad that his experience was confirmed by others, viz., that in a few cases thyroid extract did good; in a large number it produced harmful effects, while in others no effects were noticeable. Of three cases under his obser-

vation, the first was temporarily improved, but succumbed to the disease; the second did not persevere with the treatment, and subsequently died; while in the third, that of a boy, exacerbation was produced.

Dr. WALSH remarked that, as the salicylates were known to alter blood-pressure, it would be interesting to learn whether the subsidence of any affections of the skin could be explained in this way.

Dr. HARRISON (Clifton) believed now less in the value of arsenic in the treatment of psoriasis than formerly, and had practically abandoned it. His experience was that the administration of salicylates always produced much benefit.

Dr. MACKEY (Brighton) described a case of acute inflamed psoriasis in a female, aged 80 years, associated with alcoholism.

Abstinence from alcohol, and the local use of carbolized oil, together produced marked improvement.

A friend had prescribed thyroid extract, and he became very ill.

It is possible large doses of iodide of potassium would do good if not outweighed by the depression produced by the salt.

Dr. RADCLIFFE-CROCKER, in reply, said an idea was prevalent among some that vegetarianism was a prophylactic in psoriasis, but he had known a girl, aged 18 years, the daughter of a medical man, who had avoided meat all her life, and yet had well-marked psoriasis. Possibly the action of salicylates was the opposite to that of alcohol, which dilated the blood-vessels.

Arsenic undoubtedly produced benefit in some cases, but its effects had been much over-rated.

The experience of other members conveyed that, while he had some little respect for thyroid extract, the bulk of those present had none, but further investigation was needed. The connection between rheumatism and psoriasis was uncertain, but he did not know that any large proportion of patients with rheumatoid arthritis suffered psoriasis.

In the treatment of leprosy, when acute exacerbation existed, he gave large doses of quinine, but now would try salicylates, thyroid extract being unsuitable.

Referring to iodide of potassium in large doses, he considered it had valuable diuretic action, but produced intestinal catarrh, and occasionally gouty conditions if administered for too long a time.

The PRESIDENT here announced the result of the ballot.

The names of the office-bearers for the Session of 1895-6 were published in the last issue of the Journal.

The PRESIDENT exhibited a case of *Melasma* (supra-renal), in the person of a girl, aged 19 years. The illness, which was of three months' duration, followed influenza.

In 1891 she underwent a successful operation for tuberculous disease of one elbow. The pigmentation commenced on the face and lips, spreading to the whole of the body, accompanied by general debility and some dyspnoea. She is now taking tablets of supra-renal capsule.

Dr. HARRISON (Clifton), showed photographs of a case of *Rodent Ulcer* in a man, 78 years of age, a cloth-worker by trade, and of good general health. Nine years ago a small red papule appeared on the left cheek near to, if not upon, the site of a sebaceous tumour which had been removed twenty years previously. It ulcerated and spread slowly.

An ineffectual scraping was performed previous to being seen by the exhibitor, about three years ago. At that time the ulceration, which measured 5 inches \times 2½ inches, had almost completely destroyed the outer ear and the facial branches of the seventh nerve, producing distortion of the mouth and a singular pouching of the lower lip, the result, probably, of paralysis of half the orbicularis muscle. Active treatment being impossible, gradual extension is still taking place.

Dr. ABRAHAM showed the following cases:—

1. *Pityriasis rubra pilaris* of *Devergie*, in a girl aged 2½ years. The disease commenced as a vivid erythema of palms and soles, followed by desquamation; redness and desquamation of neck and face; pityriasis of the scalp; and a general xerodermatous condition of the legs and forearms. The disorder was of three months' duration.

2. *Morphœa*—two years' duration—on wrist of a lady violinist, who stated that the disordered condition of skin was first noticed after the prolonged practice of difficult passages on violin. The patient was taking thyroid gland internally, and using an ointment of carbolic and salicylic acids.

3. *Pemphigus* in a man aged 51 years, which had lasted twelve months, associated with a peculiar glossy condition of hands. Arsenic had been administered for ten months. A similar attack is said to have occurred in 1882.

4. A youth with bald patches on scalp, following ringworm and simulating erythematous lupus, which had existed upwards of three years, and were extending.

Dr. ALFRED EDDOWES. *Microscopic Sections*:—

1. A stained section of horny plug from an eruption on face and scalp, of doubtful character, containing numerous micrococci.

2. Hairs (stained) showing organisms (bacilli) in a case of "Alopecia areata."

3. Hairs (stained) from a case of Folliculitis of scalp.

Dr. CAGNEY brought forward a case of *Telangiectases* of the face in a woman 45 years of age. The condition had existed ten or twelve years, and was very marked. Blotches of bright red colour, in some instances as large as a threepenny piece, were connected by a network of dilated capillary vessels, and the appearance extended from the roots of the hair on the forehead all over the face to the upper part of the neck.

The exhibitor had applied the galvano-cautery to the larger blotches *seriatim* on the right side of the face and forehead only, and the contrast at the present time between the side that had been treated and the other was very marked, the disfigurement being almost entirely removed in the former case.

Dr. STOWERS exhibited a woman, aged 32 years, with *Lupus* of the forearms. The disease, which was of fourteen years' duration, commenced on the dorsal surface of the left wrist. Simultaneously a small tubercle developed on the flexor aspect of the right forearm, but this has not exceeded one inch in diameter. The disease on the left wrist has extended very slowly, and is now 6 inches by 4 inches, the long axis corresponding with that of the limb. Her occupation is that of a laundry-ironer.

DERMATOLOGY AT THE MEETING OF THE BRITISH MEDICAL ASSOCIATION.

July 30th to August 2nd, 1895.

THE Section will meet in the Conjoint Examination Hall, West Wing Room, Second Floor.

President: H. RADCLIFFE-CROCKER, M.D.

Vice-Presidents: McCALL ANDERSON, M.D.; MALCOLM MORRIS, F.R.C.S. Edin.; J. J. PRINGLE, M.B.; WM. ANDERSON, F.R.C.S.; H. A. G. BROOKE, M.B.

Honorary Secretaries: J. HERBERT STOWERS, M.D., 41, Finsbury Square, E.C.; JONATHAN HUTCHINSON, Jun., F.R.C.S., 15, Cavendish Square, W.

Wednesday, July 31st, 10 A.M.: President's Address.

The following subjects have been selected for discussion in the Section:—

The Pathology and Treatment of Pruritus, introduced by McCall Anderson, M.D., of Glasgow, and H. A. G. Brooke, M.B., of Manchester.

Diet in the Etiology and Treatment of the Diseases of the Skin, introduced by W. Allan Jamieson, M.D., of Edinburgh, and Walter G. Smith, M.D., of Dublin.

The following papers have been announced:—

COTTERELL, Edward, F.R.C.S. The Treatment of Syphilis by Injections of Syphilitic Antitoxin.

GALLOWAY, James, M.D. Certain Nervous Lesions of the Skin.

HARRISON, A. J., M.B. On Two Cases of Unusual Verruca Necrogenica (with Photographs).

PYE-SMITH, P. H., M.D., F.R.S. Affections of the Skin occurring in the Course of Bright's Disease.

ROBERTS, Leslie, M.D. Treatment and Prognosis of Trichophytosis based on the Physiology of the Trichophytions.

STOWERS, J. Herbert, M.D. On a Case of Dermatitis Repens (with Coloured Drawings).

PLATE V.

Fig. 11.

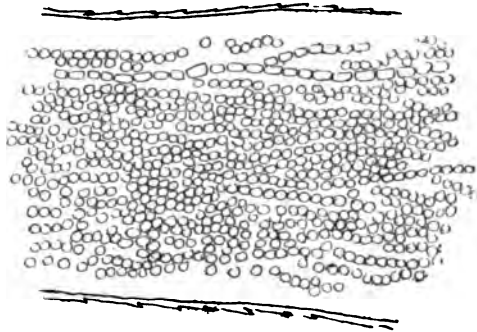


Fig. 12.

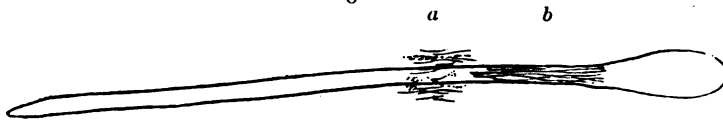


Fig. 13.

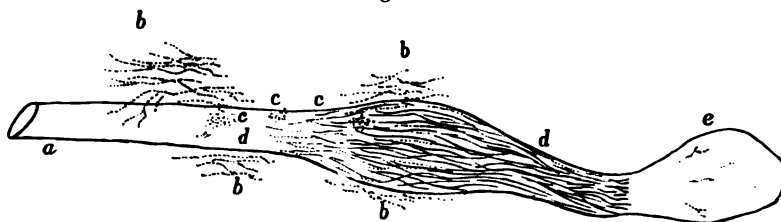


Fig. 14.

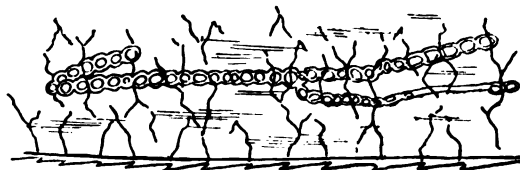


Fig. 11.—Hair from case of large-spored endothrix of scalp at stage of complete invasion. Fungus entirely within hair. ($\frac{1}{3}$ -inch objective, reduced one-half.)

Fig. 12.—Hair from same case as fig. 11 at an early stage of attack. *a*. Imperfect sheath of fungus elements round shaft. *b*. Strings of spores or joints of mycelium beneath cuticle, terminating at neck of soft bulb. ($\frac{1}{2}$ -inch objective, reduced one-half.)

Fig. 13.—Hair from case of ringworm of the beard (*T. megalosporon ectothrix*), *a*. extra-follicular portion of hair free from fungus. *b b b b*. Bundles of jointed rods outside hair. *c c*. Groups of spores on surface of hair. *d d*. Lower portion of root-shaft filled with chains of fungus elements. *e*. Spores and fragments of mycelium on surface of bulb. ($\frac{1}{2}$ -inch objective, reduced one-half.)

Fig. 14.—Portion of hair in early stage of invasion. The same case as fig. 13. Shows a string of spores or mycelial joints passing downwards towards root and situated beneath the cuticle. ($\frac{1}{2}$ -inch objective, reduced one-half.)

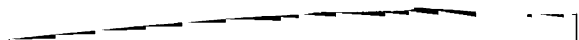


PLATE VI.



Fig. 15.



Fig. 16.

PLATE VII.

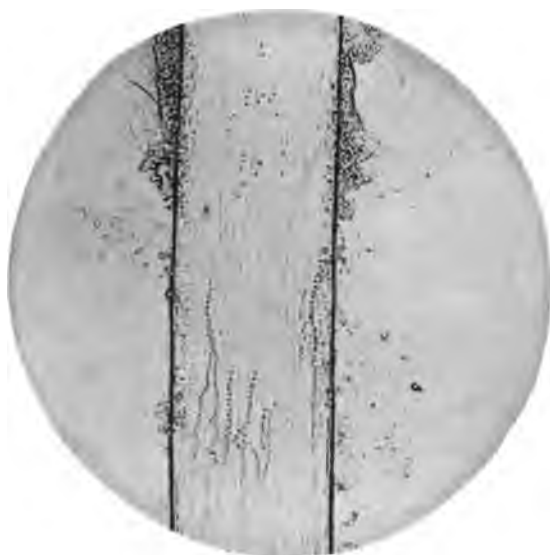


Fig. 17.



Fig. 18.

PLATE VIII.



Fig. 19.



Fig. 20.

DESCRIPTION OF PLATES VI., VII., AND VIII.

Fig. 15.—Hair from case of large-spored ringworm of scalp (*T. megalosporon endothrix*) at an early stage of invasion. Upper part of the root-stem with groups and strings of spores *outside* the hair. ($\times 300$.)

Fig. 16.—Hair from same case at stage of complete invasion, showing fungus elements entirely *within* the hair. ($\times 300$.)

Fig. 17.—The same hair less highly magnified. Sheath of fungus elements at upper part of root-stem and below this, jointed rods growing downwards beneath the cuticle.

Fig. 18.—Hair from case of ringworm of fore-arm (*perifolliculitis conglomerativa*). Stage of complete invasion, showing fungus elements entirely within the hair. ($\times 300$.)

Figs. 19 and 20.—Hair from case of beard-ringworm (*T. megalosporon ectothrix*); fig. 19 showing spores outside hair and strings of jointed mycelium or spores beneath cuticle. These are not seen plainly because not in focus. In fig. 20 these latter are seen in focus. ($\times 300$.)

The photo-micrographs here reproduced are from unstained specimens in liq. potassæ (10 per cent.), and were taken in the laboratories of the Royal Colleges of Physicians and Surgeons.

THE BRITISH JOURNAL OF DERMATOLOGY.

AUGUST, 1895.

OBSERVATIONS ON THE PARASITES OF RINGWORM.

BY H. G. ADAMSON, M.D. (LOND.), M.R.C.P.

Physician to the North-Eastern Hospital for Children, Clinical Assistant in the Skin Department of the Middlesex Hospital.

(Conclusion.)

As already stated, among 178 cases of ringworm of the scalp, in five only was a large-spored fungus found. So far as microscopical examination showed, these belonged to the group described by Sabouraud under the name of *Trichophyton Megalosporon Endothrix*, i.e., in hairs completely invaded; or in other words, in the majority of hairs over a diseased area, the fungus was confined to the interior of the hair itself.

It seems almost certain, however, that none of the cases included in this list belonged to the commoner forms described by Sabouraud as due to an endothrix fungus and which are of human origin, but rather to the unusual endothrix varieties met with by him, which are probably of animal origin. And for this reason:—did they belong to the commoner forms of human origin, they would have occurred more frequently, and not at long intervals as isolated cases among the great number of small-spored cases.*

* Unfortunately I have not been able to determine this point by means of cultivations of the fungus. At the time of observation I was unable to make cultures from three of the cases, and have since lost sight of these. In the remaining two cases, however, the cultivations on Sabouraud's "Milieu d'épreuve" did not give growths corresponding to those of either of the commoner forms described by Sabouraud.

Sabouraud's statistics* for 100 cases of "large-spored" ringworm of the scalp are as follows:—

Seventy-two per cent. are caused by *Trichophyton Megalosporon Endothrix*, and these are all of human origin.

Twenty-eight per cent. are caused by *Trichophyton Megalosporon Ectothrix*, these being of animal origin, and presenting always a kerion or other similar inflammatory condition. In addition, he describes a few uncommon forms of endothrix variety, these, possibly of animal origin.

As already observed, these five cases of "large-spored" origin belong to the "Endothrix" variety, but are probably unusual forms. I have as yet met with no cases of ringworm of the scalp in which the microscopical appearances of the completely invaded hairs corresponded to those of the *Trichophyton Megalosporon Ectothrix* of Sabouraud, and all my cases of kerion have showed the ordinary small-spored fungus (*Microsporum Audouini*).

THE LARGE-SPORED ENDOTHRIX—TRICHOPHYTON MEGALOSPORON ENDOTHRIX (SABOURAUD).

The clinical appearances were identical in four of the five cases observed, and were as follows:—

Small irregularly-shaped scaly patches looking at first sight like ordinary seborrhœic areas. On these there still remained long and apparently healthy hairs, though slightly less thickly placed than on the rest of the scalp. On closer inspection a few short, thick, broken stumps could be seen piercing the scaly mass. In scrapings from the patches broken fragments of hair were found among the scales.

Three of these children had red, raised, and slightly scaly patches on the face or body. In one instance the father, in another the mother, had a red, raised ring, the size of a shilling, on the face. In the third case two other children had each a large plaque (1½ inches to 2 inches in diameter) on the body. The fourth case had no patches on the body, nor were others in the family affected.

In the fifth case the naked eye appearances were different. The

* *loc. cit.*

lesion consisted of a ring, $1\frac{1}{2}$ inches in diameter, situated at the fore part of the scalp. The margin of the ring was formed of small red, raised papules; within this was a smooth, slightly-scaly semi-bald area, the hairs remaining consisting only of a few long ones, and a few short, brittle, broken stumps—these latter most abundant on and near the papular margin. The remaining hair follicles of the patch were plugged with hair stumps broken off at the level of the skin surface; in this case there were no other lesions either in the patient or in others of the family.

The *Microscopical appearances* were similar in all five cases. The stumps of hair could not be extracted whole, but broke off within the follicle. These stumps and the fragments of hair found in the scales were crowded with chains of large round or oval highly-refractile spores, the greater number about 5 micro-millimetres in diameter, but varying from 2 to 6 μ .

The cuticle of the hair was undestroyed, and there were no fungus elements seen outside the hair. Thus, in these completely-invaded hairs the appearances were those of "*Megalosporon Endothrix*." (Figs. 11 and 16.)

In many of the unbroken hairs, however, which could with care be extracted entire, along with the soft bulb, *conditions apparently of an earlier invasion* were found.

Surrounding the shaft at the level of its exit from the follicle, and for a short distance above and below this point, were groups and chains of spores and mycelial joints forming an imperfect "sheath" round the hair. These external elements varied considerably in size and appearance from square or rectangular "joints" arranged in chains (each joint 2 to 4 micro mm. or more across), passing through all stages to round refractile "spores" of about 6 micro mm. in diameter. (Figs. 12 and 15.) The shaft of the hair above this was entirely free from fungus.

Below in the root-shaft, immediately beneath the cuticular covering, were long chains of mycelium with short transverse joints, and in some of the chains there was a tendency for the joints to become more rounded, resembling the chains of spores seen in the fully-invaded hair stumps. The long chains, as they passed downwards, branched dichotomously in the direction of the root, the elements of the mycelial threads becoming narrower and longer, and

finally ending in a fringe, just at the junction of the soft bulb, similar to that seen in the small-spored form.

In other hairs the invasion by the fungus could be studied at a still earlier stage. Here, again, at the upper part of the root-stem, were groups and strings of spores or jointed mycelium *outside* the hair, while the portion of the root-stem below this, instead of being more or less completely filled with the fungus, presented only isolated chains. These varied in length, some consisting of a few joints, others extending as far as the neck of the soft bulb. They commenced abruptly on the surface of the hair, and, after piercing the cuticle, passed downwards beneath this in the direction of the root. (Fig. 17.)

Thus it would appear in the so-called endothrix variety, though at an advanced stage the fungus actually is confined to the interior of the hair, yet the method of attack is similar to that in the small-spored type previously described. The fungus at first forms an imperfect sheath outside the hair, and at the same time sends strings of mycelium into the hair, passing through the cuticle and growing downwards towards the root inside the hair itself. The later appearances are due to the cessation of the growth of the fungus outside the hair, while it multiplies rapidly within the hair.

In the scales taken from the body-lesions there existed only mycelial branches, as in the previous variety, but these were larger and the joints more strongly marked than in the small-spored form.

THE LARGE-SPORED ECTOTHRIX—TRICHOPHYTON MEGALOSPORON ECTOTHRIX (SABOURAUD).

The only cases in this series which corresponded microscopically with the above group were those of ringworm of the beard (6 cases) and one case of suppurative ringworm of the forearm (*perifolliculitis conglomerativa*). In each of these cases, however, the presence of the fungus also within the hair could be easily demonstrated, although, unlike the cases of large-spored ringworm of the scalp, the fungus here persisted also on the outer surface of the hair as an interrupted imperfect sheath.

Sabouraud recognizes several varieties of ringworm of the beard,

and the six cases here considered gave several different forms of cultures, but since the microscopical appearances were similar in each it will be sufficient for my present purpose to group them together. The only differences observed by the microscope were differences in the size of the fungus elements in different cases. In one case they were about half the diameter of those of the remaining five cases.

The Clinical features varied somewhat according to the stage at which the cases were observed. In two cases in which the lesion was quite recent this consisted of a circular plaque about one inch across, made up of red raised papules on an inflamed base, the papules corresponding to the hair follicles, and being largest and most abundant at the margin of the plaque, thus forming a ring.

The remaining cases showed more or less extensive areas of red, raised, infiltrated skin, here and there dotted with pustules or small scabs. Over these areas the hairs were thinned, those remaining being either short, easily removed stumps, or unbroken and firmly fixed.

The Microscopical appearances also varied according to the stage of attack. It was more easy to obtain hairs complete with the soft bulb attached than in ringworm of the scalp. In these—under the microscope—the upper extra-follicular portion of the shaft was usually free from fungus, and remained healthy looking, and covered with its cuticle. Surrounding the upper part of the intra-follicular shaft were bundles of jointed rods and groups of spores forming an interrupted sheath (figs. 13 and 19). The size of the elements of the rods varied considerably on the same hair, some being greater in length than in breadth, and having the appearance of mycelial elements, others slightly oval or circular, and resembling spores; the average diameter of these latter being 6 micro mm., while the former varied from 2 micro mm. or less up to 1.2 micro mm. across, and were two, three or more times as long as broad. The smaller mycelial elements could be traced passing gradually into the more spore-like and larger. The "groups" were made up of spore-like bodies, spherical, and of almost uniform size, viz., about 6 micro mm. in diameter.

Within the follicular part of the shaft itself, lying just (figs. 13, 19 and 20) beneath the cuticle—which remained intact—were long

strings of square jointed mycelium passing downwards towards the root, branching frequently, until, at the lower part of the shaft, they formed a dense network, ending always as a fringe just at junction of the soft bulb and shaft. The size and appearance of these elements varied also; those highest in the shaft being largest (about 6 micro mm. in diameter), and towards the root becoming gradually smaller.

On the bulb itself were irregular groups and strings of spores. In a more advanced stage the soft bulb became separated, and remained behind in the follicle. The stumps of hair thus formed had often the appearance of large spored endothrix *i.e.* their cuticle remained intact, and the hair substance was filled with strings or chains of spore-like bodies.

In a quite early stage of attack the fungus could be seen just beginning to invade the hair itself. Starting from a single spore or from a group of spores on the surface a string of mycelium could be traced piercing the cuticle, and then passing for some distance down the shaft beneath the cuticle (fig. 14).

A CASE OF RINGWORM ON THE FOREARM.

This case corresponded clinically with those described by Sabouraud under the name of "Perifolliculite agminée," and produced by a special form of fungus, the "*Trichophyton ectothrix pyogène du cheval*."*

The patient was a carman. On the left forearm was a circular plaque (3" × 2½"), red, raised, infiltrated, and with suppurating follicles scattered through it; near the margin were vesicles. The disease was of three weeks' duration.

Epilated hairs showed appearances resembling those of ringworm of the beard. Around the upper part of the root-shaft were groups of spores of about 3 micro mm. diameter, and bundles of mycelial chains. The extra-follicular shaft appeared normal; the cuticle remained throughout the length of the hair. *Within* the root-shaft beneath the cuticle were strings of short-jointed spore-like mycelium. These

* Cultures obtained from this case upon Sabouraud's "Milieu d'épreuve" had the characteristic appearances, *viz.*, large snow-white and rayed—"cultures blanches."

terminated as a fringe of "wavy" mycelial threads at the junction of the soft bulb with the shaft. The appearances were thus exactly those of the beard-hairs affected by ringworm fungus and of the hairs of an early stage of attack in the endothrix form. (See Fig. 18).

The existence of different forms of ringworm fungus has been clearly proved by the work of Sabouraud and others, though whether these are distinct species or only varieties due to differences of soil still remains a matter of dispute. Sabouraud further affirms that ringworm is caused by two totally distinct kinds of fungus, belonging to two distinct botanical families. These are the *Microsporon Audouini*, and the group of *Trichophytons*, the latter including a large number of varieties or species.

As already stated, the object of this paper bears chiefly upon the relations of the fungus to the hair, and no attempt is here made to deal with the question of plurality of species.

It may be noted, however, that the microscopical appearances in by far the greater number of ringworm cases in London Hospital practice are those described by Sabouraud as belonging to the fungus *Microsporon Audouini*, and these appearances are very characteristic, and are constant for each individual case and for cases infected by them. The sheath of closely-packed and uniformly-shaped and sized spores around the root-stem, the mycelial threads embedded in the surface of the hair beneath this sheath, and the extra-follicular shaft, cross-fractured and denuded of its epithelium make up a picture which can always be easily recognized and distinguished from the *Trichophytons*, whether these be "endothrix" or "ectothrix."

Among the large-spored forms or *Trichophytons* of the scalp and beard of this series there existed minor differences, such as in the size of the fungus elements, which were constant for each case, but the different varieties of this group could not be distinguished by the microscope alone. Even the difference between the larger groups, the endothrix and ectothrix, was only observed in the completely-invaded hair, and appeared then to be due only to the more or less abundant growth of the fungus inside or outside the hair.

The proportion of large-spored cases (*Trichophytons*) of the scalp to the small-spored cases is considerably less than that existing

in Paris, the explanation being possibly, as before stated, that the ordinary large-spored forms of the scalp, which are of human origin, are not endemic among the poorer classes in London, and the few which one does meet with are probably of animal origin. Such differences in geographical distribution have already been noted in Germany; Krösung, for example, states that ringworm of the scalp is seldom or never met with in Breslau.*

Accepting Sabouraud's division of ringworm into two chief groups, viz.:—I. Those caused by the small-spored fungus or *Microsporon Audouini*; and, II. Those due to large-spored fungi, or *Trichophyton*s, I have endeavoured to show that the manner in which the fungus attacks the hair is similar in each; also that the appearances, endo-thrix and ectothrix, in the *Trichophyton* group are due to slight modifications in the later growth of the fungus.

The observations on the manner of attack support the view (the so-called "direct theory") of Unna and Jamieson. These writers state that the fungus invades the hair by passing through the cuticular covering of the shaft and extending downwards in the hair substance. They are opposed to the theory *de détour* of many of the older writers, that the fungus grows downwards between the follicular wall and the hair-shaft until it reaches the soft bulb, here piercing the hair substance and returning upwards in the hair itself.

Finally, I wish here to gratefully acknowledge my indebtedness to Dr. J. J. Pringle, not only for the suggestion which originated this work and for permission to make use of the abundant material in the Skin Department at the Middlesex Hospital, but also for much valuable help and kindly encouragement during its progress.

To the Laboratories' Committee of the Royal Colleges of Physicians and Surgeons my best thanks are also due for sanction to publish these results of work done in their laboratories, and also for the opportunity of there continuing this present research in other directions.

* *Verhandlungen der Deutschen Dermatologischen Gesellschaft*. "Studien über *Trichophyton*," 1894, p. 89.



TO ILLUSTRATE DR. ALEX. MORTON'S CASE
OF HIDROCYSTOMA.

A CASE OF HIDROCYSTOMA.

BY ALEXANDER MORTON, M.A. M.D.

Physician for Diseases of the Skin, Glasgow Royal Infirmary.

THROUGH the kindness of Dr. James Adam, of Hamilton, whose article on Hidrocystoma appeared in the June number of this Journal, the following case has come under my observation. The patient is a daughter of the case described by Dr. Adam, and is referred to in his paper.

Mrs. H., aged 36, has been subject from her youth to outbreaks of Psoriasis, and was treated by Dr. Jamieson, of Edinburgh, about five years ago, for that disease. Her general health, she states, was very good till about nine and a half years ago, when she suffered from severe bronchitis and asthma for a period of several months. While still in the exhausted condition induced by that illness she began to suffer from unilateral sweating, affecting the *left* side of the scalp, face, neck and chest. About the same time the first "spots" or vesicles made their appearance, but she is quite sure that they began on the *right* side of the nose, and on the *right* cheek near the eyelid. In course of time similar lesions appeared in the immediate neighbourhood, especially in the space between the eyebrows, on the eyelids, and on the *left* side of the nose.

At the present time they are very well marked on the upper eyelids, over the bridge of the nose, and between the eyebrows. In the last situation they are larger than elsewhere, are separated into rows by the natural lines of the skin (though this does not show in the photograph), and come here into very close contact.

There are a few also on the *left* side of the nose and *left* side of the naso-labial region. There are three very small, indistinct and ill-defined lesions, evidently of the same nature, on the *left* side of the chin.

On the *right* cheek, near the nose, are several pin-head-sized

lesions, somewhat ill-defined. The patient states that that is the way in which the "spots" begin. Here they are pearly and semi-translucent, but lack the decidedly bluish tint of the larger lesions. They are also more acuminate in shape than when fully developed. The skin between the vesicles is normal in appearance. The rest of the face is free from the eruption.

The lesions, which project slightly above the surface, vary in size from a pin's-head to a hemp-seed, but never attain a larger size. They are often seated so closely to each other as actually to touch, but never become confluent. To the naked eye they seem to be seated superficially in the skin.

According to the patient's statement the lesions, when they first make their appearance, are pearly and semi-translucent; as they become larger and reach maturity they are bluish-white and exactly like boiled sago-grains, and when they begin to "die away" or involute they become white and opaque, somewhat like milium corpuscles, of which two exist on her face. They never burst, but shrivel and scale off, leaving very slight stains behind. The duration of the individual lesions is about three or four weeks. When punctured they give exit to a small quantity of clear bluish liquid of acid reaction, and immediately a drop of blood wells up into the orifice of the collapsed vesicle.

The number of vesicles varies exceedingly. At one time they are few and scattered; at another numerous and aggregated. They are more abundant in summer than in winter, and increase both in size and in number during a menstrual* period.

After mental excitement, as well as after partaking of anything "hot" or "spicy," such as vinegar, pickles or Yorkshire Relish, she perspires profusely on the left side for some hours, and the lesions then become more prominent, but not more prominent on the left side than the right. She is quite sure of this, and her son and daughter bear out this statement. The vesicles are at present mostly observed on the left side, but are sometimes better marked on the right. Indeed, when I first saw the case, I took special note of the fact that at that time the right side of the face was more affected than

* As in Hallopeau's case, mentioned by Mr. Hutchinson in his article in the May number of this Journal, p. 188.

the left, notwithstanding the fact that it was on the left side only that she perspired.

The patient is quite positive also that the lesions are not aggravated by exposure to a warm, moist atmosphere, as in washing or cooking. There have been no subjective symptoms of any kind till lately, when they itched very much for about a week. The patient has a split-pea-sized mole of a brownish colour over the bridge of the nose.

A point of interest in the present case is the fact that the patient has never suffered from headaches, as in the case recorded by Mr. Hutchinson, where, in his opinion, "the life-long liability to hemi-crania had something to do with the final disturbance both in function and nutrition of the skin."* The mother of my patient was also free from any tendency to attacks of headache.

The fact that both mother and daughter have suffered from this affection of the skin of the face would seem to indicate that, in addition to the probable causes mentioned by Mr. Hutchinson and Dr. Adam in their papers on the subject, heredity also plays some part in the development of the disease.

The fact, already above referred to, that the lesions do not always predominate on the side on which the patient perspires, is also worthy of note.

* *l.c.* page 140.

CLINICAL NOTES.

THE TREATMENT OF PEDICULOSIS VESTIMENTORUM.

BY W. ALLAN JAMIESON, M.D. F.R.C.P. EDIN.

Physician for Diseases of the Skin, Edinburgh Royal Infirmary, &c.

THE management of patients affected with the *pediculus vestimentorum* in hospital is comparatively easy. With a thorough scrub in a warm bath for themselves, while their clothes are subjected to disinfection, by boiling such as can be submitted to that process, or even better perhaps by washing them in water to which some paraffin oil has been added, and by exposure to superheated steam in the case of outer garments, these parasites with their ova are pretty well disposed of, for the time at least. It is far otherwise, however, in private practice. The diagnosis is not by any means easy in all instances. The patient, whose complaint is of pruritus or urticaria, has very commonly changed his linen before presenting himself to the inspection of the doctor, and in ordinary circumstances little more can be done than to take a rapid glance at the folds of the shirt near the neck. A closer inspection might be resented, and any hint of our suspicions would vex, perhaps shock, our patient. In such cases, too, there are possibly but few pediculi. Since many examples of apparent pruritus senilis own a parasitic origin, it is important to exclude this possibility. The ordinary rules as to the localities specially involved are to be followed, but occasionally if lanugo hairs are still present the ova may be found adhering to them. The patient will offer no objection to a careful examination of his skin, and with a lens the nits may be discovered attached to the fine hairs of the back. I have found them there in young subjects, and believe that this, and not always a re-infection, explains the intractability of pediculosis in some individuals. But in many old and atrophic skins there are no such hairs, and then we are forced to fall back for confirmation on secondary lesions, due to scratching. Any suspicion of alcoholism favours the view that the itching is connected with

pediculi, as those who indulge to excess in spirituous liquors or beer are peculiarly predisposed to become infested by these insects. Their careless habits as to cleanliness, added to a degree of insensitiveness of the integument, the result of such potations, render them indifferent, so that a permanent cure is particularly difficult in them. This same cutaneous anæsthesia may be existent to a certain degree in the old, even though they make complaint of pruritus.

In pediculosis corporis no remedy acts so promptly and efficaciously as petroleum, but there is an awkwardness in applying it to the general surface of the body. Incorporated in a soap, such as Calvert's Petrofenic soap, which contains carbolic acid as well as paraffin oil, it can be employed to wash the skin, the lather being allowed to dry on. In this way the eggs which have been mentioned as sometimes attached to the downy hairs are killed. The insects themselves live in the body-clothes, and deposit most of their ova there. It is thus essential that our main efforts should be perseveringly directed against them. This can be accomplished by taking advantage of the property of sulphur of slowly subliming and becoming oxidized into sulphurous acid at the temperature of the body. A piece of roll sulphur, the size of a pigeon's or bantam's egg, is enclosed in a porous bag made of muslin or canvas, and worn next the skin, day and night. The sulphurous fumes imperceptibly impregnate the clothes, and render them unsuitable for the existence of the parasites. We can thus rid our patients of a source of annoyance without communicating to them our ideas as to the cause; indeed, we can thus quietly put to the test the accuracy of our opinion. The plan suggested has proved of service to me in several instances.

A CASE OF ARSENICAL KERATOSIS.

BY J. F. PAYNE, M.D., F.R.C.P.

Physician to St. Thomas's Hospital, &c.

A LONG course of internal administration of arsenic has often been observed to produce certain permanent, or, at least, very chronic changes in the skin. Excessive pigmentation is the commonest, and may be very often observed in those who have been treated with the drug for Psoriasis, Lichen planus, or chronic Pemphigus. A rarer consequence is thickening of the epidermis on the palms and

soles, with formation of horny masses resembling corns, which was first observed by Mr. Hutchinson, as a result of arsenical medication. In the case now brought forward both kinds of changes were observed, a fact which strengthens the argument for their causal connection with arsenic.

Mr. R. S., aged 46, first came to me in July, 1894, complaining of an affection of the palms and soles. The palm of the right hand, though the epidermis was not generally thickened, showed numerous elevated patches of thick, hard epidermis, from one-eighth to nearly one-fourth of an inch in diameter, resembling corns. These were chiefly seen on the palm and palmar aspects of the fingers; also along the outer margin of the hand, at the edge of the palm. There were a few on the back of the hand, and rather more on the backs of the fingers.

The left hand showed a similar condition, less extensively distributed. There were similar small corns along the margins of the palm, but hardly any on the flat surface; a few on the backs of the fingers, but none on the dorsum of the hand itself.

Both feet were affected in a similar manner. There was a general, though not quite universal, thickening of the epidermis on the soles, and this condition was extending on the sides and backs of the feet, and on the heels, with corns like those on the hands; and the latter were seen on the toes also. There was no evidence of excessive sweating. *Pigmentation* was also very marked. The face was uniformly dark, and the whole of the trunk was covered with mottled brown patches, which extended in a less intense form to the arms and legs. On the right leg was a very distinct dark brown mottled patch some four inches square. On the whole, the appearance and distribution of these pigmented patches were such that they could hardly be attributed to anything else than arsenical pigmentation.

Other signs of arsenical poisoning were few. The patient complained of smarting in the eyes, but there was no nausea or other disturbance of the gastro-intestinal tract, and the tongue was clean. It is perhaps worth noting that he complained of insomnia. His general health was good.

In addition to the signs and symptoms above mentioned there were a few chronic patches of psoriasis on the scalp and on the abdomen.

The history of these various troubles threw a clear light upon their origin. The patient had suffered for many years from psoriasis, which had been much more extensive than it then was. He first sought advice at a hospital, and afterwards consulted a well-known dermatologist, in March, 1885, who gave him a prescription which he had carefully preserved and used ever since without further reference to the prescriber. It contained *liquoris sodæ arseniatis*, ℞; *liquoris arsenicalis*, ℥ij in one dose, to be taken three times a day. This prescription he had followed almost continuously for more than nine years, till the very time I saw him; and as he thought the medicine he had received at the hospital also contained arsenic, he must have been under the influence of the drug for decidedly more than ten years. The patient was confident that it had a powerful influence on the psoriasis, that if he left it off the eruption returned, and that fresh outbreaks were rapidly quelled by its use. The duration of the palmar affection was uncertain as it came on insidiously, but it had been becoming more noticeable for three or four months.

I can, therefore, have no doubt that the case was one of Arsenical Keratosis or Tylosis, as originally described by Mr. Hutchinson. A very similar case was described by Dr. Pringle in this Journal for 1891 (p. 890); and cases are referred to in papers by Dr. Brooke (p. 19), and Dr. Radcliffe-Crocker (p. 169), in the same volume, which should most probably bear a similar interpretation. In this case there was no indication of hyperidrosis or of any tendency to the production of epithelial cancer, and the absence of other arsenical symptoms was remarkable.

The treatment consisted in stopping the use of arsenic, and applying purely local treatment to the psoriasis. For the hands I prescribed a collodion containing salicylic acid to be painted on; and for the feet an ointment containing the same medicament. When the patient was seen a fortnight later, the corns on the hands were scaling off, though not quite gone. There was little improvement in the feet, where the epidermic masses were very thick, and further measures were resorted to. These I need not describe, as I do not know what effect they had, the patient preferring, as before, to carry out the prescriptions himself, without needless interference on the part of his doctor.

REVIEWS.

LEPROSY IN ITS CLINICAL AND PATHOLOGICAL ASPECTS.*

THE history of the literature of leprosy must, in all future times, be closely associated with the work of two Norwegian physicians, the late Dr. Danielssen and Dr. Hansen, and students of the disease in its more scientific aspects will welcome this work as presenting in compact form a statement of the views entertained by the younger observer regarding its clinical aspects, pathology and etiology.

The first work of the authors on the disease was published in Norwegian, which means that it was really a sealed book to most of us, and we must congratulate ourselves that it occurred to them to think it desirable to present a comprehensive statement of the result of their studies in a language more generally understood.

The present translation, by Dr. Walker, is from the German edition, and he appears to have successfully attained to his first aim of absolute accuracy in meaning, the style being simple and clear. There are five plates from photographs inserted in the text, illustrating tuberculous leprosy of two years' duration, of six years' duration, and after breaking down of the nodules. Maculo-Anæsthetic Leprosy is illustrated by two plates, one showing the condition after two years' duration, and the other after recovery, when the disease is supposed to have extinguished itself, but in which the injuries which it inflicted while active remain in local forms of paralysis and muscular atrophy, etc. The term Maculo-Anæsthetic, chosen by the authors, is appropriate to the symptoms. They regard the Tuberculous and Maculo-Anæsthetic forms as presenting no sharp distinction. Every case of nodular leprosy becomes "mixed" in time, for in such

* *Leprosy in its Clinical and Pathological Aspects.* By Dr. G. Armaner Hansen, Inspector-General of Leprosy in Norway, and Dr. Carl Looft, formerly Assistant-Physician to the Lungegaards Hospital. Translated by Norman Walker, M.D., F.R.C.P. Ed. With numerous photographs and coloured plates. (Bristol: John Wright and Co. 1895.)

cases an anæsthesia is never absent. The two forms are to be regarded as the same disease, with varied intensity in the action of the bacilli.

The book contains a full record of Hansen's long experience and multiplied investigations, all the newer doctrines in regard to the etiology of the disease having been carefully sifted by experiments.

Dr. Hansen and Dr. Looft believe that Bordoni-Uffreduzzi cultivated tubercle bacilli instead of leprous bacilli, and that there is no such thing as leprosy of the lungs, intestines, bones, or kidneys.

The bacilli may fill the entire cell body, but they never penetrate into the nucleus. The functions of the lymphatic glands as filters are well shown in leprous glands. In Maculo-Anæsthetic leprosy the skin affection is a bacillary one, which precedes or accompanies the neuritis, and is not a tropho-neurosis.

Bullæ are regarded as trophic symptoms, as they have never been able to find bacilli in them, their marked symmetry being also in favour of their nerve origin. They have never seen bullous eruptions of the mucous membranes. Most maculo-anæsthetic patients become in time purely anæsthetic. The authors consider that these patients no longer suffer from leprosy, but only from its results.

The difference in virulence between the two forms of leprosy is looked upon as depending not in a difference in the virulence of the bacilli, but in a difference in the soil in which they live, and the interesting statement is made (and is borne out by statistics given in the tables) that the nodular form prevails in the western parts of Norway, where the climate is moist, and the maculo-anæsthetic cases in the eastern districts, where the climate is dry.

Dr. Hansen's views concerning heredity, as regards leprosy, are well known. They are clearly stated in this volume, and are strengthened by the expression of philosophical views regarding the laws of heredity in general.

The authors have studied preparations from the infected rabbits of Melcher and Ortmann, and as they found in them caseous degeneration and myelo-plaques they do not consider that the disease from which the rabbits suffered after inoculation was leprosy.

The chapter on treatment shows how carefully all the vaunted remedies for leprosy have been tried in Norway, but, alas! with a uniformly negative result. The results of the treatment in the

Lungegaards Hospital "are nothing to boast of, but they show, according to Dr. Danielssen, that leprosy at its commencement can be cured." In their opinion this is true, but they make the reservation "that the cure is not due to the treatment, but to the natural development of the disease."

There are valuable tables of cases showing the frequent complication of nodular leprosy with tuberculosis, the proportion of tuberculosis in maculo-anæsthetic leprosy, the proportions of the two forms of leprosy, and the results of isolation in Norway. There are no fewer than eight well-executed chromo-lithographic plates, illustrating the histology of the disease.

I have said enough to show that the work is indispensable to every author who deals with leprosy, and when I add that the letterpress fills only one hundred and twenty-five short pages, and that in these pages every important problem connected with leprosy is duly weighed, I need hardly add that it should be read by every physician who is interested either in Pathology or in Dermatology.

G. THIN.

A SYSTEM OF GENITO-URINARY DISEASES.*

THIS large and elaborate work, which constitutes Part II. of the "System of Genito-Urinary Diseases, Syphilology and Dermatology," by various distinguished American writers, contains an enormous mass of well-arranged information regarding syphilis. When we point out that the volume consists of two parts, each of which is embodied in a well-bound book of some 464 pages, a fair notion may be obtained of the bulk of the work, and the labour expended in its production.

No less than twenty-three contributors have assisted in writing the various articles, which cover a most extensive range, such subjects being treated of as the history and geographical distribution of syphilis, the etiology of the disease, and syphilitic affections of the skin, eye, ear, nervous system, and other parts and organs of the body. The illustrations are profuse, and on the whole good, and the coloured plates of chancres and chancroids, diseases of the eye, and

* *A System of Genito-Urinary Diseases, Syphilology and Dermatology*, by various Authors. Edited by Prince A. Morrow, A.M., M.D. (Edinburgh and London: Young J. Pentland), 1894.

syphilides upon the skin, are decidedly admirable. Speaking of this book from the point of view of a dermatologist, we should say that the syphilitic affections of the skin are well described and excellently illustrated, and that the same remarks apply to diseases of the tongue and mucous membranes. It would need an advanced neurologist to adequately criticize the sections that deal with syphilis of the nervous system. We mention this to show how extensive is the range covered in this book; but cerebral and spinal syphilis appear to be well and comprehensively treated, and are illustrated by numerous striking clinical cases. A long section is devoted to the treatment of syphilis, and numerous references are given to the formulæ of various authorities.

We think it well comes up to the estimate of the Editor, expressed in the preface: "A complete and systematic treatise on syphilis and chancre, which should be thoroughly up to date, embodying the most recent advances made in our knowledge of these diseases, and at the same time essentially practical."

MARMADUKE SHEILD.

A PICTORIAL ATLAS OF SKIN DISEASES AND SYPHILITIC AFFECTIONS.*

WE have had the pleasure of seeing and studying the new "Pictorial Atlas of Skin Diseases," issued with the authority of the Staff of the St. Louis Hospital, Paris. By those who have had the advantage of seeing the Museum of the Hospital, and especially the wonderful casts of morbid conditions of the skin by Baretta, the opportunity of being reminded of their visit to the French centre of Dermatology will be much valued. In addition, this work promises to be a valuable illustrated text-book of skin diseases.

Part I. of the English translation is before us, and is a faithful reproduction of the Atlas as it appeared in its French form. The plan followed is to give reproductions of some of the well-known casts in the Museum, with descriptive letterpress coming from the hands of the physicians under whose charge the patients furnishing the models have been treated. When we mention that the names of

* *A Pictorial Atlas of Skin Diseases and Syphilitic Affections in Photo-Lithochromes, from Models in the Museum of the Saint Louis Hospital, Paris, with Explanatory Woodcuts and Text.* Edited by J. J. Pringle, M.B., F.R.C.P. (London: F. J. Rebman, 11, Adam Street, Strand.) Part I. 10s. 6d.

Besnier and Fournier appear appended to two of the descriptions in this part, the character and standard of the work will be readily appreciated. Woodcuts are also added as diagrams to point out the position of the lesions represented by the photo-lithochromes.

As to the illustrations and their description we have nothing to say that is not laudatory, although we would desire to distribute our praise in different degrees.

Let us take Plate (I.), of *Lupus vulgaris*. A cast of the face must necessarily present still and expressionless features, and the closed eyelids in the present case do not detract from this impression. The Plate is an exact reproduction of the cast, and we have therefore the disadvantage of seeing the lesions of *Lupus vulgaris* as if on the cadaver. The distribution of the lesions is, however, accurately depicted, and an excellent attempt to give the colours of a disease so difficult to portray is made. The case is one of undoubted tubercular affection of the skin, and the description with the aid of the diagrammatic woodcut leaves no doubt as to its characters. In this case the characters are so described that the distinctions between doubtful cases of *Lupus erythematosus* and tubercular *Lupus* come out in relief, and thus it forms an excellent description for the neophyte as well as the advanced student in Dermatology to study. In addition, the treatment and progress of the case are remarked on—points of value to those who have actually to deal with similar conditions.

The Plate (II.) illustrating *Dermatitis Herpetiformis*, in our opinion, is the gem of this portion of the Atlas. The back of the hand and forearm are the parts depicted, and the texture of the skin, as well as the characteristics of the lesions, are so well portrayed as to leave nothing to be desired. We have rarely seen a representation of skin disease give so vivid an impression of the actual conditions. This Plate has already had to serve for purposes of demonstration, and amongst those of several other Atlases this was recognized as being by far the most striking in its likeness to the condition under consideration. In the publisher's preface it is stated "that the illustrations will chiefly represent *typical* cases of common diseases." We hereby think that the editors will uphold this illustration as representing the usual form of *Dermatitis herpetiformis*; but we shall not grumble if, amongst others, we obtain illustrations of some

of the rarer forms of disease so well represented in the Museum of the St. Louis Hospital.

The fasciculus (III.) dealing with *Chancres of the Female Genitals* is important, not only on account of its illustrations, but also on account of the descriptive letterpress by Professor Fournier. The opportunity is taken of depicting the common forms of syphilitic infection of the vulva, and of describing their characters. We observe that the writer strongly insists on the absence of any sharp projecting ridge from the periphery of these lesions, and goes on to say: "As a fact, syphilitic chancres are never characterized by the celebrated perpendicular edges which have been unduly ascribed to them by observers, considerably before our time, and which have clung, and been continually ascribed to them as a matter of tradition," an opinion, we imagine, which will be endorsed by most of our readers.

The fourth photo-lithochrome represents the model taken from the thigh of a patient suffering from *Purpuric Erythema*. This plate represents very accurately a severe example of this lesion. In the discussion of the case Dr. Feulard takes the opportunity of drawing attention to the distinction between purpura rheumatica and purpuric erythema. He classifies the case depicted as the latter on account of the absence of joint pains of any severity, and the appearance of the eruption, which in some places was that of true erythema. The prolonged rise of temperature, and the eruption of the lesions in crops, are suggestive of rheumatic relationships.

The English edition is annotated and superintended by Dr. J. J. Pringle, a guarantee that every care has been devoted to this part of the work. The descriptions are excellent in their English dress. We hope that an atlas so useful for purposes of study, and as a key to the diagnosis of maladies of the skin, may prove equally satisfactory to the publisher, who has had the enterprise to place it before the medical public in such an attractive form.

JAMES GALLOWAY.

SOCIETY INTELLIGENCE.

DERMATOLOGICAL SOCIETY OF LONDON.

At the Ordinary Meeting held on July 10th, 1895,

Dr. CLIFFORD brought forward a well-marked case of *Urticaria pigmentosa* in a boy who, at three months of age, suffered from urticaria, which showed itself in large round and oval, raised tubercles, as well as in wheals. It was most marked on the face and neck, and was very red in these regions. The child could not mix with other children, as to strangers he looked as if he were suffering from measles. The eruption extended over the whole body, including his scalp, palms and soles, and has persisted till the present time. He is now over nine years of age. The raised patches are not so red as they used to be, and have been gradually fading away. They have a yellowish-brown tint. The face is now pretty clear of them, except that some staining of the skin marks the places where they previously existed.

On the body they are still very distinct, and he has marked factitious urticaria. The boy has always had good health, except that his digestion is easily upset. He has to be careful in his diet, any indiscretion making the spots and irritation worse.

Dr. COLCOTT Fox brought forward a case of *Rodent Ulcer over the sternum*.—A woman, aged 57, with a large shallow, painless ulcer over the upper end of the sternum. A progressively extending lesion had existed there for eighteen years, and the patient gave ten years as the duration of ulceration. The floor was covered with pale weak granulations, but there was no evidence of tuberculous lesions. The border was cleanly cut, not undermined, and surrounded by a narrow, slightly raised, cartilaginous-looking rim. From these symptoms Dr. Fox suggested the diagnosis of Rodent Ulcer. There was no history or evidence of syphilis.

Dr. GALLOWAY presented (1) a young woman, 23 years of age, the subject of *Lupus erythematosus*. For three years the condition has existed, but not in a degree to be very unsightly. But during the cold weather in January the disease had advanced very greatly, and had progressed since that time. The patient is very subject to chilblains affecting the hands, feet and ears. At present patches of the typical, superficial erythema, powdered over in part with brownish-yellow scurf, occupy large areas of both cheeks, the nose, the lobules of both ears, and several outlying spots.

The question asked was whether treatment by operative means should be adopted in this case—a course urged by the patient—or whether medical treatment should be tried in the first instance. It was the general opinion that drugs such as ichthyol or salicylate of soda should be tried fairly in the first instance previous to linear scarification or treatment by caustics.

Dr. Galloway also showed (2) the case of a boy of 6 years of age who had been brought to Charing Cross Hospital two days previously. He suffered from a widely-spread, papulo-vesicular eruption, affecting the face, neck, trunk and extremities, the lower extremities being least affected. On the neck and trunk the eruption was arranged in a distinctly grouped manner, although there were numerous isolated spots on the intervening areas of skin. On the hands the patient showed a profuse eruption of vesicles closely resembling those of Dysidrosis. The spots generally were surrounded with a little erythema, but this was not a marked feature, although where irritation had occurred a tendency to general dermatitis was visible. On the front of the left ankle and foot were two large bullæ, closely resembling in shape and size those figured in Plate 2 of the Pictorial Atlas of the St. Louis Hospital Museum. The condition commenced about seven weeks ago.

At first sight the patient suggested an eruption of scabies, but this diagnosis had been carefully excluded. The opinion expressed by Dr. Galloway was that the case was one of *Dermatitis herpetiformis juvenum*, and this was agreed to by most present at the meeting. Dr. Adamson drew attention, however, to the numerous dysidrotic vesicles on the hand, and maintained the diagnosis of a Dermatitis of eczematoid type connected with Dysidrosis. The patient has been admitted, and will be reported on in future.

Case shown by Mr. HUTCHINSON, Junior. The case was brought before the Society as being *tertiary Syphilitic Ulceration with warty growth*, which remarkably simulated a tubercular lesion. It was situated on the anterior aspect of the forearm, just above the wrist, and alongside of four or five ulcers, with somewhat undermined edges, was a considerable amount of warty growth, like that of *Verruca necrogenica*. The edge was of a livid purplish colour. It had existed for two years on the forearm, but had healed in parts, leaving supple scar with pigmented edge. The patient was a man of forty-five, who had lost one brother from phthisis. He had himself suffered from a severe attack of secondary syphilis ten years ago—chancre, rash, sore-throat, and subsequently relapsing sores on the tongue. He had been treated for the present lesion thoroughly with iodide of potassium, with only slight improvement.

Lately, however, under the liq. hydrargyri perchlor. (without iodide,) and red oxide ointment locally, great improvement had taken place, and it looked as though the whole would heal.

Mr. MALCOLM MORRIS showed (1) an unhealthy-looking boy, aged 18, with a history of universal eczema seven years ago, and of *Tinea tonsurans* ten years ago. The disease of the nails, for which he was shewn, was first noticed three years ago. The nails of the fingers of the left hand were thickened to three or four times the normal; their colour was greenish-yellow, passing into black at the free edge, which was somewhat thickened and ragged. Their surface was rough, and pitted like the rind of an orange. There was swelling and marked thickening over the nail-groove. The nails at their free extremities were separated some distance from the nail-bed. The boy complained of pain up to the first interphalangeal joint, and of numbness over the inner side of the hand and ulnar side of the forearm. The enlargement was more uniform in the nails of the two outer fingers, the pitting more marked on the middle and index-fingers. The thumb-nail was unaffected. On the right hand there was only slight thickening and deepening in colour of the nail of the ring-finger, with a tendency to pitting. The other nails were normal. Itching was also complained of in the affected fingers. There were no signs of eczema, psoriasis, or trichophyton of other parts of the body. The general health was good. The results of scraping and microscopical

examination of the affected nails were negative as regards the presence of fungus. The general opinion expressed was that the case was a *Dystrophy due to perverted innervation*.

Mr. MORRIS showed (2) a case of an unusual form of *Scrofulodermia* in a boy aged 14 years. It had been present about six years, and had been painful for the last month. On the radial surface of the wrist was a slightly elevated patch, dark-reddish in colour, about one inch and a half in diameter, the surface being somewhat rough, cracked, and scaly, on the inner side of which was scar-tissue about half an inch square. On the front of the same wrist was a round, dark-red, verrucose growth, about four lines in diameter, circular and without scarring. On the posterior surface of the right thigh was a large circular patch eight inches in diameter, connected with another circular patch higher up, which extended to the perinæum and to the inner surface of the thigh. The connection between the two measured an inch and a half in length, and was mainly scar-tissue. The patches were slightly raised and had well-defined margins. The surface was dark red, covered in places with yellowish scab resembling *Lupus erythematosus*. In the centre were islets of scar-tissue. No distinct lupus nodules were to be made out. On the outer surface of the thigh were three scars, said to have been left by patches similar to the large ones. There were marks of old strumous abscesses on the right side of the neck. The general health was good. All agreed with the exhibitor that the case was one of Tuberculosis of the skin, of the type described by Leloir as *Lupus vulgaris erythematoïdes*.

Mr. MORRIS showed (3) a case for *Diagnosis*, in a woman aged 47, who first noticed a small warty lump in the right popliteal space eleven years ago, which has gradually increased, and has been troublesome for the last two years owing to its itching. In the right popliteal space was a raised oval growth with a flat surface, the edge of which rose abruptly from healthy skin. It was firm to touch and purplish-red in colour, the surface being rough and warty, and showing the orifices of the follicles. Above the main mass was a smaller one about one and a half inches by half an inch in diameter, of the same characters as that previously described, but of softer consistence. On the inner side of the main growth was a papule, purplish in tint, flat, and not umbilicated. No similar lesions were present elsewhere.

All agreed with the exhibitor that the case was an unusual form of *Lichen planus hypertrophicus*, some similar examples of which had already been exhibited at the meetings of the Society.

Mr. MARMADUKE SHEILD brought forward the case of a married woman, aged 47, of fair complexion, who had over the lumbar region posteriorly a group of irregularly distributed, deeply pigmented papules and tubercles, occupying an area the size of a soup-plate. Some of these were pustular at the summit, others covered with blackish scabs. On the left leg were some scars suggestive of old syphilis, but there was no history of that disease. The diagnosis lay between drug-rash, possibly from bromides, *pus infection*, and a syphilide. In the absence of facts bearing upon the case the majority of members leaned toward the second view.

Dr. SAMUEL WEST showed (1) a *chronic Pruriginous Rash for Diagnosis*. The patient was a cachectic man of 39 years of age, the subject of congenital syphilis. He had had the rash, for which he was shown, upon his body for two years. The rash consisted in diffuse spots on both legs and extending upwards as far as the waist, but not altogether symmetrically, being much more marked on the right side than the left. It was made up of red blotches, with hardly any scaling, at first vivid red or purple in colour, subsequently fading and leaving dark brown pigment stains. It was of very long duration and sometimes recrudesced. Some spots, however, had completely disappeared, while others had taken their place. The development of the rash had gone on continuously over the whole period of two years.

It itched a great deal, especially at night; there were no spots above the waist on any part of the body, and had not been.

The rash was thought to be not syphilitic, not psoriasis, not lichen planus, nor was it, as far as one could judge, parasitic. The diagnosis was left undetermined.

(2) *Chronic Syphilitic Eruption*, with excessive crusting on the soles and heels of both feet of many years' duration, in a man of the age of 42, who had had a very bad attack of syphilis twenty years before, and had been ill with it for more than two years. He was shown because of a thick, scaly crusting upon the soles and heels of both

feet. That on the right foot began eight years ago, that on the left two years ago. The crusts were massive, from a quarter to half an inch thick in places. They formed very rapidly, and even after they had been removed by various means in a day or so they became almost as thick as before. A good deal of pain was produced, so that the patient found it difficult to walk or stand. He had been under all kinds of treatment, with which he was fully acquainted, had taken large doses of iodide of potassium, arsenic and mercury, and had treated his foot locally in a variety of ways, but without any improvement. The patient was shown with the desire to obtain some hints as regards the cure of the case. The disease was evidently of a syphilitic nature.

(3) *Chronic Eruption on both legs, for Diagnosis.* A healthy young woman of the age of 24, unmarried. The rash consisted of spots of a reddish or coppery colour, with little scaling, slightly raised above the surface and somewhat tender. They were all the seat of considerable itching, especially at night. The rash extended to about four inches above each knee, where there were a few discrete spots.

Below the knee the spots became more abundant, and formed irregular patches, which increased in size towards the ankles.

On the inside of each foot, extending for some distance on to the sole, the largest patches were found. There was very little scaling, and the general appearance at a distance was very much like that of a chronic tertiary syphilitic eruption, but there was no history of syphilis in the case nor other signs of it, nor any reason to believe that the patient had ever had that disease.

There were no spots on the rest of the body, and never had been.

The patient's history was that this eruption first commenced, without any reason, two years ago and lasted for about six months. She then lost it entirely, but has had a return of it, which has now lasted for about eight weeks. It is not, at the present time, getting any better. The general opinion appeared to be that it was a form of *Psoriasis*, but that diagnosis was not unanimous.

THE DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND
IRELAND.

At the Ordinary Meeting held on Thursday, June 26th, Dr. P. H. PYE-SMITH, F.R.S., in the Chair,

Dr. SHEPARD TAYLOR read notes of a case of *Abnormal Growth of Finger-nail*, and exhibited the specimen.

The patient, a woman, aged 73 years, had enjoyed excellent health all her life-time, and had never suffered from gout, rheumatism, or any skin affection. Her five children were alive and in good health. She stated that eleven years ago she injured the right thumb close to the nail. Shortly afterwards the latter commenced to grow "inwards" and assumed a rounded form. The index finger-nail of the same hand developed in a similar way until it reached one inch in length, the specimen now shown. Dr. H. Collier, of Great Yarmouth, removed it by operation, and sent the specimen to Dr. Taylor for exhibition.

The PRESIDENT remarked that hypertrophied nails often reached a great length, and occasionally assumed the form of the claws of birds of captivity. The same malformation was noticed in caged lions. A similar condition obtained in rabbits, the teeth growing to considerable length when unexposed to friction. The specimen exhibited reminded him of an excrescence like a ram's horn which was removed from a sebaceous cyst on the neck of an old woman by the late Mr. Edward Cock. The specimen was now in the Museum of Guy's Hospital.

Dr. ALFRED EDDOWES showed (1) a patient, a cook, with *Hypertrophy of the Nail* of the left great toe, which curved backwards. The disordered condition was limited to two-thirds of the nail-bed, the nail being six times its proper length, and the condition was attributable to the wearing of a short boot. The large toe-nail on the right foot was similarly hypertrophied. The nails were stated to have been untrimmed for upwards of twenty-five years. The appendages had been worn through holes in the boots cut for the purpose. Dr. Eddowes proposed cauterizing the nail-beds for the purpose of cure.

Mr. L. A. BIDWELL advised the entire removal of the matrix to

prevent new nail-formation, and that the skin should be brought together over the wound in each instance.

The PRESIDENT attributed the condition to an affection of the matrix.

Dr. S. WILKS drew attention to the atrophic lines seen on nails contemporaneous with acute illnesses, the periods of health being indicated by increased thicknesses.

Dr. EDDOWES showed (2) a case of *Angio-keratosis* on the outer side of the right leg, in the person of a married woman aged 50 years. Above were several varicose veins which formerly extended over the part involved, the keratosis appearing to have obliterated their varicosity. At one time the affected skin was excessively rough.

The treatment adopted consisted of applications of creolin and Unna's zinc-glue, which, in the exhibitor's opinion, had produced satisfactory results.

Mr. L. A. BIDWELL showed a man, aged 74 years, with a *Rodent Ulcer* on the thigh. The affection commenced four years since as a wart which was exposed to friction, the resulting cicatrix breaking down and developing into an ulcer. This latter was now of considerable size and devoid of granulations. The condition was unattended with pain, and the glands were unaffected. At one time an islet of skin existed upon it which was excised, together with the base and edges of the ulcer. He intended to excise the disease again freely.

Dr. P. S. ABRAHAM had examined the specimen microscopically, and found that the Malpighian layer extended into the growth. He agreed with the exhibitor that it was a typical rodent ulcer.

Dr. CROCKER considered the appearance suggested a slow-growing epithelioma rather than rodent ulcer.

Mr. BIDWELL promised to exhibit the specimen at the next meeting.

Dr. P. S. ABRAHAM showed the following cases:—(1) An eruption due to the ingestion of *Bromide of potassium*. The patient, a woman 25 years of age, had been the subject of epilepsy for upwards of thirteen years, and had taken medicine the whole period. Ten months ago she was bitten on the arm by a woman, on the site of which the first bromide lesion appeared. There were now several

large ulcerated masses, which seemed to have commenced as warty growths rather than papules.

(2) (For Mr. WARREN TAY) *Prurigo*, with unusual features. The patient, a young woman, had large discrete papules on the arms and legs, and a few on the back and chest. The patient, who was subject to urticaria, but who had no skin disorder during childhood, stated that the eruption commenced about five years since as "heat-bumps," and was always accompanied with itching. The papules, which were of large size, were unlike those met with in Hebra's *Prurigo*.

Dr. STOWERS remarked that the absence of glandular enlargement, so generally met with in long-lasting typical *prurigo*, was against the conclusion that the case was of that nature, and in favour of urticaria.

Dr. CROCKER considered the initial disorder to be urticaria with permanent lesions, or nodules as he would call them, and anticipated that wheals would be seen from time to time if the patient remained under observation. He objected to the term *prurigo* being applied to such a case.

Dr. ABRAHAM stated Mr. Tay was treating the case with creolin baths and creolin ointment. He called it *prurigo* because Mr. Tay and others regarded the case in this light. He believed the term "*prurigo*" was sometimes used to indicate any lesions caused by scratching, and he considered the papules in this case were so caused. He did not associate it with the *prurigo* of Hebra.

Dr. SHEPARD TAYLOR thought it a case of *Urticaria papulosa*.

The PRESIDENT said that the papules did not constitute the urticaria, but that the urticaria left the papules.

(3) A child, 2 years of age, who from birth had a rough, scaly, pigmented condition of the skin, chiefly on the body, with marasmus and some glandular enlargement. Dr. Abraham thought it might be a case of *Xeroderma pigmentosum*. The scalp was involved.

Dr. STOWERS saw nothing in the case to distinguish it certainly from ordinary xerodermia, extraneous matter being superadded.

Dr. CROCKER regarded it as *Seborrhœa Capitis et Corporis*.

The PRESIDENT considered the patient to be the subject of *seborrhœa*, although an unusually young example.

Dr. EDDOWES viewed the case as similar to one he had exhibited at a previous meeting. He was much impressed by the "saddle-

shaped" nose, and suspected syphilis, which, in his opinion, was confirmed by other symptoms, including persistent nasal catarrh. The xerodermic condition of the skin, in his judgment, was probably a later stage of the "parchment-like" skin of syphilitic children.

(4 and 5) Two cases of *Lupus*, or an allied disease. The elder patient, a woman, 55 years of age, had an extensive lupiform eruption on the left hand and wrist, spreading serpiginously. It commenced twelve years ago, and seven years later was treated by erosion. Four months since a similar patch appeared on the right wrist. It had been contended that multiple lupus appeared at different points simultaneously, but Dr. Abraham had seen cases in which this did not hold good. He at first suspected syphilis.

The younger patient, a girl, had undoubtedly true lupus on the navel of four years' duration.

The PRESIDENT stated that in his experience multiple manifestations of lupus did not appear simultaneously.

Dr. STOWERS read notes, and exhibited a case of *chronic disease of the Nails*. The patient, a house parlour-maid, aged 36 years, was generally healthy, but had suffered from anæmia and debility. Previous to her mother's death, now ten years since, she was engaged in nursing her constantly day and night, remaining in the house for many months, with the result that she had felt more or less unwell ever since. She never had skin disorder, or disease of any kind, neither had any been known among the members of her family, but for upwards of seven years she had been subject to migratory pains in, and some swelling around, the joints of the extremities.

Two and a half years ago the nail on the right index-finger became speckled, and indented at the distal end, followed by thickening, splitting, and some separation from the finger beneath. Previous to any noticeable change, pain of a pricking character was experienced, together with some hyperæsthesia.

The nail is discoloured, and irregular in structure and shape. Longitudinal furrows and separations exist upon it, giving it the appearance of thin plates lying upon each other, but unevenly attached. Beneath this an accumulation of epithelium and *débris* exist. The striæ do not reach to the matrix, the attached part of the nail having numerous white specks and grooves upon it, with minute

round indentations. The nails become brittle, and break away unless frequently cut and attended to. Next in order to become deranged was the thumb-nail of the same hand, which followed within a few weeks.

The same description as of the index-finger holds good, except that the tendency to fold back is more conspicuous, and gives the appendage a more concave appearance, the nail being separated at the sides to a greater extent than in the centre.

The remaining three nails on the right hand are slightly thickened, and have longitudinal superficial ridges and grooves upon them, but at present are not separated from the fingers beneath. The third nail to become deranged was that of the left index-finger, which is the most disordered on that hand at present, though to a less degree than the right. The remaining four nails are slightly affected, but in a similar way. The patient stated that two years ago the nails of the feet exhibited the same alterations, the large toes being each as bad as the right thumb-nail is at present. They have since so far recovered that but slight nutritional disturbance exists, and the small toes have hardly an abnormal appearance.

Dr. Stowers remarked that the idiopathic disorders of nails of a structural kind, which are not of syphilitic origin nor dependent upon micro-organisms are most frequently associated with the constitutional diseases known as psoriasis and eczema.

Psoriasis unguium is unaccompanied with inflammatory disturbance, severe pain, or suppuration of the matrix, but is often associated with the characteristic eruption on the skin, more or less marked, so that a distinct connection appears between them.

Eczema unguium is rarely seen apart from eczema of the hands (eczema manuum) or a long-continued dermatitis, and usually occurs as an extension of the inflammatory process, which affects the matrix secondarily.

While admitting the difficulty of exact diagnosis, yet, having regard to the duration and progress of the case, the exhibitor inclined to the opinion that the nature of the change producing the nail affection in this instance resembled that of psoriasis rather than eczema. The patient was sent to him by Dr. R. H. Wilbe, of Finchley.

The PRESIDENT observed that in his experience this condition was more common in old than young people, and it was extremely difficult

to benefit them. He thought that it occurred without either eczema or psoriasis. He would be pleased to hear the opinions of other members as to its pathology and treatment.

Dr. SHEPARD TAYLOR mentioned the case of a boy whose nail appeared to be affected with a mycosis. The instance before him appeared like nails which had broken down as if dissolved by a caustic.

Mr. BIDWELL mentioned a case with similar characters, which seemed to benefit more by change of scene and exercise than anything else. The patient was a barrister.

Dr. CROCKER considered these cases were benefited by arsenic administered internally. He thought the case described more closely allied to eczema than psoriasis, but admitted uncertainty. He considered arsenic in such an instance had a selective action.

Dr. WILKS spoke of the power arsenic had in producing disorder of the skin, both when administered internally and applied externally. He described his experience of the way in which the fingers and nail matrices inflamed and swelled in students who dissected at the time that arsenic was first employed as a preservative agent.

Dr. STOWERS, in reply, stated that he had seen the condition he had described in connection with both eczema and psoriasis. The reason why he thought it possible, in this instance, to be more nearly related to the latter was, that he had never seen the same disorder of the nails more marked than when psoriasis existed concurrently in other parts of the body. The occupation of the patient suggested the necessity of putting the hands frequently into irritating fluids, &c.; but the curious fact remained that the nails of the feet had been affected in like manner. All the nails had been more or less involved. Even those which had not exfoliated showed considerable nutritional disturbance. He would give arsenic, as a remedy, a fair trial.

The PRESIDENT announced that the *next meeting* of the Society would take place on the 23rd of October.

THERAPEUTIC NOTES.

TREATMENT OF ECZEMA OF THE HANDS AND FINGERS IN OUT-PATIENT PRACTICE.

Dr. Unna recommends (*Monatsh. f. Prakt. Derm.*, Bd. XIX., 1894) the following :—

R.	Zinci oxidi	40 parts by weight.
	Cretæ preparatæ	20 „
	Liquoris Plumbi acetatis	20 „
	Olei Lini	20 „

The first two ingredients are to be well blended, the last two well mixed, and then the whole to be worked into a paste. *Sig.* Zinc Paste.

R.	Plumbi oxidi	50 parts by weight.
	Aceti venalis	75 „

These are heated in an earthenware vessel for some ten minutes, and then oleum lini, 25 parts, are added. *Sig.* Lead Paste.

R.	Zinci oxidi	20 parts by weight.
	Sulphuris	20 „
	Cretæ præparatæ	20 „
	Olei Lini	20 „
	Aquæ Calcis	20 „

The finely-powdered solids are well blended, and the emulsified fluids are added. *Sig.* Zinc Sulphur Paste.

The above preparations are useful, inasmuch as their application does not hinder the patients from following their occupation. They are to be well rubbed in at night, gutta-percha tissue applied and fixed by a few turns of bandage. The paste can thus be left on during the day whilst various household duties are performed, and renewed at night. For bricklayer's eczema Unna recommends the application of tar mixed with spirit and castor oil. This can be used by the patient during his work.

For more chronic forms of eczema :—

R.	Chrysarobini	10 parts.
	Adipis lanæ	60 „
	Ceræ venalis	80 „
	Chrysarobini	10 „
R.	Acidi salicylici	20 „
	Adipis lanæ	50 „
	Ceræ venalis	20 „

M. To be moulded into sticks.

These "pencils" are to be applied by the physician when the patient attends.

For trade-ezema, when "dry," the following paste may be used at night time. It is well rubbed into the hands, then greased, and gloves worn. In the morning the hands need only to be well oiled, and the daily work can be resumed.

R. Unguenti zinci } āā 10
 Resorcini }
 Terræ siliceæ 2
 M. Fiat Pasta.

Sig. To be used at night.

TREATMENT OF ALOPECIA AREATA IN CHILDREN. (*Therapeutic Gazette, from Rev. Intern. de Méd. et de Chirurg. Pratiques, September, 1894.*)

FEULARD employs the following at the Hospital *des Enfants Malades*:—The hair is cut as short as possible with scissors, and the following ointment applied:—

Vaseline } of each 225 grains
 Lard }
 Precipitated Sulphur 45 grains
 Salicylic Acid 15 grains

Next morning the head is shampooed with salicylated soap, and then friction is applied with a soft brush soaked in this mixture:—

Alcohol } of each 8·88 ounces
 Tincture of Rosemary }
 Corrosive Sublimate $\frac{1}{2}$ grain

Once a week the patches may be painted with a brush soaked in:—

Essence of Winter Green } equal parts
 Ether }

THIOFORM. (*Wiener Med. Wochenschr., September, 1894.*)

STEUER describes Thioform as a greyish-yellow, very fine powder, a dithio-salicylate of bismuth which is odourless and tasteless, insoluble in water, alcohol, and ether, but slightly soluble in alkalies.

He used it as a powder with great success in five cases of varicose ulcer of the foot, which had been unsuccessfully treated with iodoform. He also had excellent results from the use of a ten per cent. thioform ointment in four cases of soft chancre and two of favus.

Thioform is dearer than iodoform but much lighter, so that its employment is much more economical.

SALOL IN NON-PARASITIC SYCOSIS. (*Therapeutic Gazette, February, 1895.*)

DR. ABBOTT CANTRELL reports three cases of non-parasitic sycosis treated by salol, but the results do not confirm the anticipations of Greetzer as to the value of the method. In one case a fairly rapid cure was obtained with an ointment of the strength of 20 grains to an ounce of petrolatum, but in the other two cases the results were "very unsatisfactory."

BRITISH MEDICAL ASSOCIATION.

July 30th to August 2nd, 1895.

At the approaching meeting the following papers will be read in the Section for Dermatology, in addition to those already announced :—

- ANDERSON, William, F.R.C.S. The Treatment of Adenoma Sebaceum.
 DAVIES, Arthur T., M.D. A Case of Lupus ; Result of Treatment by Thyroid Feeding (with Photographs).
 EDDOWES, Alfred, M.D. Brief Notes on Corns—true and so-called (Drawings and Microscopic Specimens).
 FOX, T. Colcott, M.B. Two Short Papers.
 HUTCHINSON, Jonathan, jun., F.R.C.S. Microscopic Sections, and Drawings of Case of Rodent Ulcer of Forearm.
 LIDDELL, John, M.D. (Harrogate). Case of Pityriasis Rubra Pilaris, Clinical Features, and Minute Anatomy (with Microscopic Sections).
 MACKEY, Edward, M.D. (Brighton). Cheiro-pompholyx in association with Eczema.
 MANSON, P., M.D. Short Communication on the Guinea Worm (with Microphotographs).
 PERNET, George, L.R.C.P., M.R.C.S. Pemphigus.
 SMITH, Gilbert, F.R.C.S. Edin. (Birmingham). Note on a Case of Lichen Planus Verrucosus.
 STARTIN, James, M.R.C.S. One or two Living Specimens of Uncommon Eruptions, and Short Notes.
 STOKER, George, M.R.C.P.I. The Treatment of Alopecia Areata by Oxygen Gas.
 WALDO, Henry, M.D. (Clifton). On Alopecia Areata.
 WALKER, Norman, M.D. (Edinburgh). The Methods of Examination of the Skin Histologically.

Friday, August 2nd, will be devoted to the demonstration of cases. Notice should be sent by members intending to exhibit, with description of cases, to J. H. Stowers, M.D., not later than July 27th.

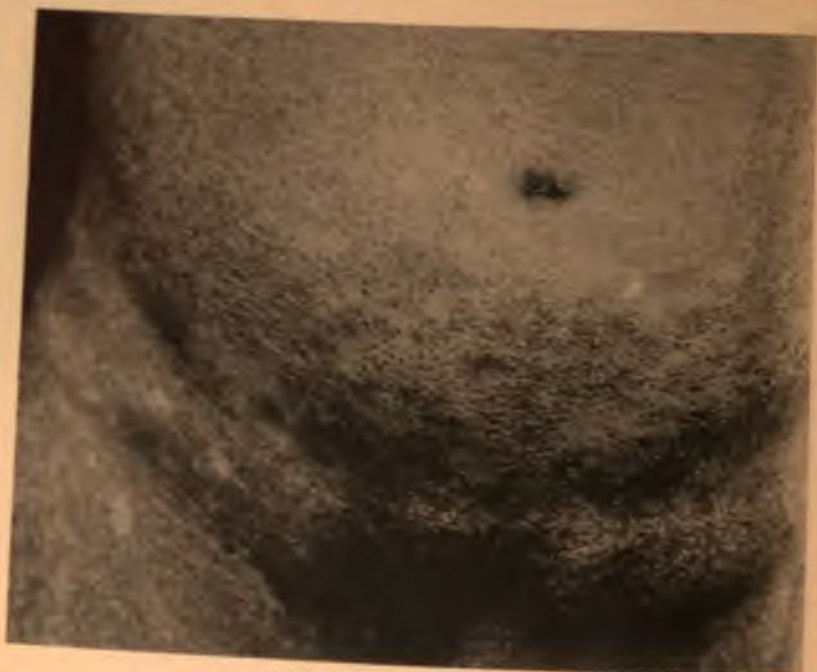


Fig. 1.



Fig. 2.

DR. SAMUEL WEST'S CASE OF PITYRIASIS RUBRA PILARIS.

THE BRITISH JOURNAL OF DERMATOLOGY.

SEPTEMBER, 1895.

A CASE OF PITYRIASIS RUBRA PILARIS (DEVERGIE),
WITH A SHORT ACCOUNT OF THE DISEASE.

BY SAMUEL WEST, M.D., F.R.C.P.,

Assistant Physician and Demonstrator of Skin Diseases at St. Bartholomew's Hospital, Senior Physician at the Royal Free Hospital, etc.

(*Illustrated.*)

JOHN JONES, aged 58, came to the Hospital complaining of an affection of the skin, of which he gave the following account:—Two years ago some small pimples appeared on the forehead, which itched a good deal. The rash rapidly spread to the whole face. From the face it gradually spread over the head and body, so that in five or six weeks the whole body was covered. The rash was scaly from the first, never moist or running, and always dry, though not so dry at first as it is now.

The general health had not been in any way affected. He had been under treatment for the last seven months, the diagnosis, he stated, being made of eczema. No improvement or change had taken place, and so he came to St. Bartholomew's Hospital.

He had had syphilis at the age of 20, but had never had any return of it. He was very intemperate when young, but had been steady for many years. There was no similar complaint in his family, nor anything of interest in the family history.

The following description of his condition was taken on 16th April:—The patient is a well-nourished man, looking in fairly

good health, and except for the rash has nothing the matter with him.

The eruption covers the whole body, from the crown of the head to the sole of the foot. Its general character is red, the redness being most marked below the waist, between the thighs and upon the legs, while on the upper part of the abdomen it is of a brownish colour. Upon the shoulder, arm, neck and face, the skin is covered with bright glistening scales. These scales occur over the whole body, but are most marked on the shoulder, the back and the elbows, and about the sacrum between the natal folds. In the latter place they form large patches of a mother-of-pearl appearance, but nowhere have they the characters of the scales in psoriasis, and there is hardly any scaling over the knees. Over the head, neck, back, thighs and arms the normal lines of the skin are greatly exaggerated, so that the case resembles one of ichthyosis. Over the whole body, even in the parts which are most affected, there are small patches of healthy skin, some of them as large as a shilling, but many of them so small as to be easily overlooked. They stand out in strong contrast with the redness round them, so that at a distance they look as if they were small scars. In some of these patches the skin appears to be perfectly normal, in others there are small papules to be seen. The hairy scalp is covered with fine scales, which give it much the appearance of seborrhœa, but on the crown, which is bald, the skin is somewhat cracked and fissured. The patient has been bald for many years, but does not think that he has lost more hair recently. The conjunctivæ are somewhat congested, and the lower lids swollen and everted. There is but little thickening of the skin anywhere, even in the parts most affected.

The eruption begins as a papule. The initial lesions are best seen over the lower part of the front of the abdomen and in the epigastric region. Elsewhere the disease has passed beyond the papular stage, but in most of the small patches of healthy skin, as already stated, papules are to be seen. The individual papules are quite small, round, about $\frac{1}{16}$ th inch in diameter, distinctly raised above the surface, with a red base and a cap of scales. They are for the most part arranged in lines which follow the normal lines of the skin. When they run together they form at first long ridges along these lines. The scales are very adherent, and when picked off leave a little

depression in the top of the papule, which is red, but does not bleed. The penis seems to have escaped entirely. The hands and soles are covered with horny scales, which have cracked in places, and look like the skin of a crocodile. The cracks, however, do not bleed, nor are they painful. The nutrition of the nails on the hands is affected, for they have grown irregularly and are ridged, but they are firmly fixed. On the feet the nails are for the most part black and dropping off, their place being taken by masses of scales of a dirty grey colour.

All the functions are performed naturally, and the patient looks and feels well. He is out of work, for the reason that his employers will not have him at his work, and not that he is unable to work.

I took him into the Hospital, intending before treatment was commenced to excise a piece of the skin and make microscopical specimens of the initial papules. Unfortunately, in the few days that were allowed to elapse, the disease spread so rapidly that all the initial papules were lost, and an examination of other parts of the skin seemed unnecessary.

I ordered the patient to be soaked daily in a hot soda bath (8 ozs. of washing soda to thirty gallons of water) for about twenty to thirty minutes, to soften the skin and remove the scales, after which he was to be well rubbed down with a bath-towel and thoroughly oiled all over with carbolated oil, 1 per cent. At the same time I placed him upon a mixture containing 5 minims of *Liq. arsenicalis*, which was to be taken three times daily.

The bathing and oiling were continued throughout his stay. The arsenic was rapidly increased up to 15 minims three times a day, and continued for several weeks, but without any real improvement; for, although the scales were removed by the bathing and oiling, and so far the appearance of the patient was improved, the disease seemed to be really as active as ever. In all other respects he was well, and the arsenic in no way upset him.

After nine weeks of the arsenic treatment I decided to place him upon thyroid extract, and gave him at first two and later three tabloids daily. He took them without any general disturbance, and almost immediately improvement commenced in the skin.

His present condition (August 12), after taking to thyroid extract for five weeks, is as follows:—

There is little to be seen in the skin now but a general redness—the colour is not vivid as it was, but of a dull brownish-red, and is largely due to pigment staining, such as is seen after erythema—for on pressing the blood out of the skin the impression is not white but brown.

There is still slight general desquamation, but the skin has lost its hardness, is moist and supple, and, except that a little thickening still remains, it feels normal. The palms and soles are soft, moist and supple, and so are the buttocks, back and shoulders. The nails of the fingers are growing normally, and the scaly masses on the toes are almost gone; and here too the nails are becoming normal. The ectropion, which was so marked at first, has now gone entirely in the left eyelid, and is hardly perceptible in the right.

The patient is in excellent health, and appears to be on the high road to complete recovery.

There can be no doubt, I think, that the thyroid extract has been the active agent in the cure of the case, for the improvement was coincident with the administration, and continued steadily day by day.

Attention was first drawn to this affection by Devergie in 1854, after whom the disease is usually called Pityriasis rubra pilaris of Devergie. The most complete monograph is that by Besnier,* published in 1889, which is based upon twenty-eight cases, most of them of French origin, three described in this country, one in New York, and two in Christiania. Hilton Fagge, under the name of Rhinoderma, also records a case in the Guy's Hospital Reports, a model of which Dr. Pringle informs me is in the Guy's Museum, No. 827.† Recently, besides the case which is the subject of this article, another has been recorded by Dr. Abraham during the present year.

The disease is, therefore, a very rare one, for in forty years hardly more than thirty cases in all have been put on record. The initial lesions consist of small papules which give the skin, at a distance, the appearance of "cutis anserina." These papules are capped with a small mass of scales which project from the mouth of the dilated

* *Annales de Dermatologie et de Syphiligraphie*, 2nd Ser., t. X, 1889. Nos. 4, 5, 6.

† This case appears to have been missed in most of the references to this disease, and the credit of rescuing it from oblivion is due to Dr. Pringle.

hair-follicles. The papule is, indeed, nothing more than the hair-follicle dilated with these epidermic accumulations and surrounded by a little inflammatory infiltration, giving the papule its red colour. These epidermic scales form blunt conical masses with their base upwards, and they extend down the hair-follicle as far as the entrance of the ducts of the sebaceous glands. They can be detached by the finger or the forceps without causing bleeding, and then leave a cup-like depression in which the vessels of the deeper layers of the skin can be seen, but which do not bleed. As these papules increase in number the exudation in the skin round them increases, and the normal lines of the skin become greatly exaggerated, so that in the later stages, when the infiltration is considerable, the skin lines look very much like those met with in Ichthyosis.

As the disease progresses the papules become confluent, and the whole skin assumes a diffuse red colour, becoming thickened and covered with scales. In this stage the appearance is somewhat like that of diffuse Psoriasis, or even Dermatitis Exfoliativa.

The four stages of the disease are the following:—(1) The period “anserina”; (2) the perifollicular hyperæmia; (3) the superficial infiltration of the papillary layer of the dermis; (4) the diffuse smooth redness with exaggeration of the folds of the skin, and desquamation (Pityriasis).

The initial lesion may appear in almost any part of the body, but its favourite seat is upon the exposed parts, viz., the hands and the face, and occasionally the neck and extensor surface of the forearms. Upon the hands the common seat is the backs of the second and third phalanges and the dorsum of the hand. Upon the face it often appears first on the forehead, eyelids, or chin. The initial papules do not occur upon the scalp or upon the parts of the body covered with large hairs, but they may be found on any part of the body where the lanugo-like hairs are found.

Even when the disease is fully developed, and in most parts of the body has passed beyond the papular stage, still patches of skin may be found here and there which, except for the initial lesions, are otherwise healthy. This is important in respect of diagnosis. Attention was drawn to these patches of healthy skin in the present case.

Once started, the disease usually extends locally for some time, and often quite slowly. Subsequently it develops with greater

rapidity, and may then, in a very short time indeed, become general.

The disease may be met with at almost any age, but generally, it is stated, commences in infancy or during youth. It is, as a rule, most common in males. There is nothing in the family history with which the disease can be connected, and its cause is quite unknown. The general outbreak may be preceded by an initial stage of varying duration in which no characteristic lesion may be present to give the diagnosis; nothing, perhaps, but a diffuse redness, the cause of which is obscure. As soon as the typical lesion appears, a few weeks may be sufficient for it to spread very widely.

There is generally no constitutional disturbance of any importance throughout the disease, and but few symptoms in the skin itself.

The affection runs a very chronic course, but its duration is very variable. It is liable to relapse, but any given attack may develop very suddenly and terminate as rapidly, though it usually lasts for some months, and occasionally even some years.

When once the disease begins to resolve it may rapidly disappear.

Finally, it is never fatal.

The essential lesion is an accidental anomaly of the cornification of the epidermis, especially at the mouths of the follicles, affecting first the walls of the follicular infundibulum, the mouths of the sebaceous glands, and very frequently the bed of the nail. When the initial lesions are present the diagnosis is easy.

In the more advanced conditions of the disease, or when the initial lesions are not evident, the diagnosis may be very difficult.

The diseases with which it is most likely to be confused are, in the first place, Ichthyosis; (2) Lichen planus; (3) other forms of Pityriasis rubra; and (4), lastly, Psoriasis.

Nosologically its closest affinities are with Psoriasis.

The treatment which appears to be most useful is that commonly employed in Psoriasis, namely, arsenic in full doses, frequent bathing, with inunction and ointment of chrysarobin, salicylic acid, tar, and its derivatives, &c. In my own case the success which followed the administration of Thyroid Extract was very striking.

In conclusion, I wish to express my thanks to Dr. Colcott Fox for the interest he has taken in the case, and for his great kindness in placing the literature of the subject at my disposal.

A CASE OF PITYRIASIS RUBRA PILARIS, WITH HISTOLOGICAL EXAMINATION.

BY J. LIDDELL, M.D.,

Physician to the Harrogate Royal Bath Hospital.

(*A Paper read before the Dermatological Section of the British Medical Association, Wednesday, July 31st, 1895.*)

THE morbid condition of the skin to which I desire to direct your attention is one of comparative rarity. The only cases hitherto recorded in this country are those described by Tarral,* Hillier,† Tilbury Fox,‡ Hilton Fagge,§ and Jamieson.|| It is probable, however, that some cases have been overlooked or confounded with other conditions. Yet its clinical features are so distinctive that it may be recognized with ease. The name Pityriasis rubra pilaris very well indicates the clinical features, since there is exfoliation of scales, redness of the skin, and evident implication of the hair. Besnier,¶ in his excellent monograph, deals with the subject exhaustively, and Dr. W. Taylor** has given some beautiful illustrations of the disease under the name of lichen ruber.

I will now proceed to give the clinical history and treatment of a case which was under my care last year. Next, I shall give the results of the histological examination and conclude by briefly referring to the pathogenesis.

H. H., aged 12 years, a school-girl, the subject of a skin affection, was admitted into the Heatherdene Convalescent Home, Harrogate, on March 6th, 1894. She stated that she did not remember on what part, or at what age, the eruption began. She knew she had suffered from it as far back as she could remember. No other member of the family was affected by a skin disease. I was informed that the family was in very poor circumstances, and that the girl, in respect

* Mentioned by E. Besnier in *Annales de Derm. et de Syph.*, vol. x, 1889.

† "Handbook of Skin Diseases, 1865.

‡ "Skin Diseases," 1873.

§ "Quain's Dictionary of Medicine," 1894.

|| *Trans. Med. Chir. Soc. Edinb.*, 1889-90.

¶ E. Besnier, *Annales de Derm. et de Syph.*, vol. x, 1889.

** *New York Medical Journal*, January 5th, 1889.

to food and cleanliness, was much neglected. Her general health was good. She was bright and intelligent. There was occasional itching. Perspiration was entirely absent. It was noticed that when she was undressed and the skin exposed to the air she shivered, whatever the temperature of the room.

The Condition of the Skin.—There was a universal reddish hue of the skin, which was dry, harsh, and scaly. Much of it was covered with an eruption which assumed the form of either papules or scaly patches. The papules were grey, or reddish-grey, dry, hard, rounded, with flat or conical summits. They varied in size from a pin's-head to a millet-seed, a few being the size of a hemp-seed. The flat papules had a horny scale, more or less thick, on the top. The conical papules were mostly truncated and umbilicated, their shape being due to a dry, horny cone surmounting the papule. These scales and cones had the appearance of dirty yellow wax. One or more atrophied hairs were in some instances seen at the summit of a cone. Each papule was surrounded by deep furrows which crossed each other at right angles, the furrows being the natural lines abnormally developed. On some areas a scaly accumulation was seen round the hair-follicles, and when the fingers were passed over these a sensation was conveyed as if they were passing over a fine file. It was evident that the papules took origin in these from the scales increasing and the surrounding skin becoming thickened. With respect to the patches, they were raised and dry, with a scaly or horny covering, and were situated on a reddened surface. The eruption was distinctly symmetrical, not only in distribution but in intensity. The fine linear markings of the skin were much exaggerated, as were also the lines of flexion. The distribution of the morbid condition was as follows :—

The Upper Limb.—On the dorsal aspect of the hand there were numerous papules over the metacarpal bones, and the proximal phalanges. These papules were conical, and were as a rule pierced by one or several hairs broken off close to the summit of the cone. The second and distal phalanges were covered with grey scales. The nails were deeply furrowed longitudinally, and some were marked transversely. The palmar surface showed the skin thickened, immobile, of a deep red colour, and uniformly covered with grey scales.

The cutaneous folds were deep and broad. Around the wrist were numerous greyish-red flat papules. Small grey papules extended up the arm, especially on the dorsal aspect. On the elbow the skin was red, slightly raised, and covered with hard grey scales. These patches had a certain resemblance to psoriasis; the scales, however, were duller and horny. In the bends of the elbows were red scaly patches. On the upper arms were grey conical papules. There were deep furrows in the axillæ with broken horny ridges between them.

The Lower Limbs.—The condition of these corresponded with the upper. The nails, however, were greatly hypertrophied and claw-like, and thus differed in appearance from those of the fingers. The papules, which were not so abundant on the feet, extended up the leg and thigh. There were patches on the knees with a hard horny covering. This was broken up into small blocks by a series of straight lines intersecting each other more or less at right angles. In appearance these patches resembled ichthyosis. Each popliteal space had an oblong scaly patch. On the buttocks and sacrum there were yellowish cribriform patches.

Trunk.—Numerous papules were scattered over the trunk, especially round the waist and on the posterior folds of the axillæ.

The Head.—The face had a peculiar, tense, stretched appearance, and was covered with very fine adherent scales. There were no papules on it.

The scalp was covered with grey or yellowish-grey scales and crusts. The hair was dry and lustreless.

Treatment.—On April 26th she was transferred to the Harrogate Royal Bath Hospital, when I prescribed the sulphur baths and a resorcin ointment. Subsequently a salicylic acid and creasote ointment was used to the patches. On June 20th she was discharged very much improved. There were still a few papules, but the patches were barely perceptible. The skin was much softer and smoother.

Histological Examination.—Three small pieces of skin were removed from the patches, hardened in corrosive sublimate and spirit, and embedded in paraffin. Serial sections were then cut with the rocking microtome.

Commencing the examination with the epidermis, it is seen to be greatly increased in thickness. The rete malpighii shows great functional activity and is markedly hypertrophied. There is a down-

ward growth producing an elongation of the papillæ and an extension laterally, attenuating or even obliterating them. The lowest cells are actively proliferating, the palisade cells staining deeply. Mitotic division is present in many instances. In the central and upper part of the rete there are cells with perinuclear vesiculation. These cells afterwards become flattened and apposed to their neighbours. The prickly cells are very distinct. *The stratum granulosum* is hypertrophied. The granules of Waldeyer stain steeply. *The stratum lucidum* is sometimes apparent, and occasionally there is no evidence of it. *The stratum corneum* shows very considerable thickening. The lower cells are frequently packed close together, forming a dense layer. The middle and upper cells are arranged in an open network. There is an excessive growth around the hair-follicles, forming very marked elevations. There are other elevations produced by a conical upgrowth of the rete, and having no evident relation to the hair-follicles.

The cutis vera shows only slight evidence of inflammation. The superficial blood-vessels are dilated, and there is a moderate number of leucocytes. Very occasionally, however, a considerable collection of leucocytes may be found close to the rete malpighii. There is a slight increase, at some parts, of the connective tissue.

The hair and its follicle exhibit conspicuous morbid changes. It has just been stated that there are elevated growths around the follicles. These are the so-called circumpilar cones, which are produced by an exaggerated keratinization of the root-sheath. Numerous concentric, stratified, horny lamellæ are formed, which grow upwards to a very considerable height around the hair and deepen the infundibulum. On reaching the summit of the cone they turn outwards and downwards and become continuous with the lamellæ on the surface of the stratum corneum. The rete ascends for some distance into the base of the cone. Nucleated cells are abundant in it, being found even near the summit. Transverse sections show the lamellæ arranged in a series of whorls around the hair.

The next point is one of considerable interest and importance. The cells of the outer root-sheath show great activity, they rapidly proliferate and form an enormous rounded mass at the base of the follicle. At certain parts the surrounding connective tissue grows into the mass and detaches a portion of it, which always includes some of the palisade cells which are continued downwards from the

rete. Next the mass becomes cylindrical, with the palisade cells forming a ring at the periphery. A papilla is soon seen at the lowest part, with fusiform cells rising above it. Then more fusiform cells are seen, and eventually a young hair. Young hairs in all stages of development and of varying structure are found, and it is evident that they arise from the detached mass of epithelium in the manner described. Thus in examining a follicle we find an old atrophied hair in the infundibulum; below, the production of young hairs proceeding, around new hairs pushing their way to the surface. Henley and Huxley's layers are represented in these new hairs by a thick ring of small round nucleated cells.

In the *sebaceous glands* very serious alterations occur. Those near the borders of an affected area are represented by a very small amount of gland tissue, the cells in some instances being without nuclei. The nucleated reproductive cells which normally line the basement membrane are absent. The glands are seen compressed and invaded by the active proliferation of the cells of the outer root-sheath. In some follicles sebaceous glands are absent. Again, an actively growing small sebaceous gland may be found connected with a young hair.

Changes also take place in the *sweat-glands*. Broad prolongations of the rete, composed of small round cells, are continued downwards, forming the upper part of the canal. The lumen is diminished and sometimes obliterated. The middle and lower part of the tube is atrophied. In the coils the cells are atrophied and sometimes disorganized. As regards the external opening, it may be blocked by the excessive growth of the corneous layer.

The *arrectores pilorum muscles* exhibit atrophic change, their fibres being thinner and their nuclei smaller than normal.

In respect to the nature of the pathogenesis I have little to say. It is apparent that the alterations in the epidermis, hair-follicle, sweat and sudoriparous glands do not follow any change in the corium. On the contrary, they are primary and independent of any change in that structure. But what the nature of the chronic irritation is that produces the abnormal activity of the rete, resulting in hyperkeratinization, we have no knowledge. From the circumstance that the lesions are symmetrical, some would regard the disease as a tropho-neurosis.

(For the ensuing Discussion, see page 302).

AFFECTIONS OF THE SKIN OCCURRING IN THE COURSE OF BRIGHT'S DISEASE.

BY P. H. PYE-SMITH, M.D., F.R.S.,

Senior Physician to Guy's Hospital, etc.

*(Read before the Section of Dermatology of the British Medical Association,
July 31st, 1895.)*

THE only cutaneous disorder hitherto generally recognized as occurring in Bright's disease is the Erythema leve (not læve) of Willan. His original description in 1808 ("Cutaneous Diseases," vol. i, p. 475), was followed by Bateman and subsequent writers. He notices its uniformly smooth and shining surface, the red patches becoming confluent, and its association with anasarca. He describes it as occurring both in young and old patients, particularly in those who are intemperate, and as not always accompanied by dropsy. He also observes that the apparently slight inflammation may end in local gangrene.

Erythema leve is a superficial dermatitis which owes its characteristic appearance to the fact that it appears on the surface of skin made thin by dropsy. It may be the result of local irritation from pressure, and the term has been applied to the first stage of a bedsore. But as it appears on the dropsical limbs there is no evidence of external irritation in its locality or spread, and it is seldom seen in the anasarca of cardiac or hepatic disease. It is also quite distinct from the local recurrent erythematous or erysipelatous dermatitis which leads to elephantiasis of the legs. So restricted, the term may still be used to describe the inflammatory blush which sometimes appears on the legs and thighs swollen by renal dropsy. In its pathology it should, however, be separated from other forms of true erythema (*E. multiforme*, *E. iris*, *E. bullosum*, *E. nodosum* and *Urticaria*) and be regarded as a dermatitis readily excited on a dropsical skin, just as pleurisy, inflammatory œdema of the lungs, and sometimes inflammation of the pericardium, the larynx, or the peritoneum are observed in patients suffering from disease of the kidneys.

There are, however, other forms of dermatitis which not unfrequently occur in the course of chronic Bright's disease.

1. There is a bright red diffused rash which appears chiefly on the trunk, less often on the neck, arms and thighs, and very seldom on the face, hands or feet. It is distinguished from the somewhat similar rash produced by natural or artificial diaphoresis, by its locality, by the absence of sudamina, and by its appearing when no hot-air baths, or other means have been used to produce sweating, and when the skin is harsh and dry. It does not, as a rule, either itch or smart, and only lasts a few days. I have most often seen this "roseolous" rash in cases of chronic tubal nephritis.

2. There is a papular eruption, with large discrete rather dark red pimples seated on a dry, rough and sometimes scaly surface. This I have most often seen on the outer side of the thighs and legs, the shoulders and extensor surface of the forearms, but it may also affect the loins and the abdomen. I have never seen this "lichenous" on the face, or on the hands and feet.

3. Apart from the mere coincidence of eczema with Bright's disease, there may be observed in some cases a moist dermatitis resembling eczema in its aspect, but occupying the neck, the arms or the legs, without affecting the flexures of the joints, the face or the ears, without the irritation commonly present, and without preceding attacks of eczema.

4. On two occasions I have seen a very extensive and profuse dermatitis closely resembling the universal exfoliative dermatitis of Wilson, very red, very scaly, occupying the scalp, palms, soles, and genitals, as well as the trunk, face and limbs. It has come on after the symptoms of Bright's disease have appeared, in cases of chronic interstitial nephritis with little dropsy, and with cardio-vascular changes already apparent.

Different as these forms of dermatitis are in their anatomy, they have certain common characters apart from their occurring in patients suffering from the same primary disease. They are superficial and leave no trace behind when they disappear, as they often do, or after death. They run an acute or subacute, not a chronic, course and seldom recur after they have departed. They are, so far as my knowledge goes, never pustular. They are occasionally purpuric, but this is rare, so that they offer a contrast with the hæmorrhagic erythema of rheumatism and *E. nodosum*. The subjective symptoms are usually slight.

With respect to prognosis, they usually occur in the later stages of

the renal disease, and therefore may be not infrequently present at the time of death. But they often disappear long before this, and their appearance does not coincide with any special aggravation of the other symptoms.

As to their pathology, I am not inclined to connect them with uræmia except by a natural coincidence; for we constantly see this condition in its most characteristic and fatal form without any cutaneous eruption, and each of the forms of dermatitis I have described has been seen where there were no other symptoms of uræmia. Rather, I think, should these inflammations of the skin be associated pathologically with the retinitis, the serous inflammations, and the pulmonary œdema to which patients with Bright's disease are liable.

With respect to the form of renal disease with which they are associated, I do not remember seeing any of them in acute cases of nephritis with dropsy, either in children or adults; nor in cases of lardaceous disease of the kidneys. They have either occurred in the later stages of chronic tubal nephritis, or at any stage in the course of chronic granular degeneration with shrinking of the renal cortex. I have not noticed any relation to gout, or to plumbism, or to intemperance.

The treatment I have found useful, when local discomfort has called for it, has been entirely external, and the vehicle an ointment rather than a lotion. Carbonate of lead, oxide of zinc, calamine or bismuth, have appeared to be the most useful applications, and sometimes inunction with olive oil or vaseline has been more efficient than any more active treatment.

In conclusion, I would remark that none of these affections (excepting E. leve) are common, and my chief object in drawing attention to the subject is to elicit the experience of those who, I doubt not, will be able to fill up, and perhaps to correct, these imperfect outlines.

I have not referred to the valuable paper on the subject by Dr. Le Cronier Lancaster (*Clin. Trans.*, 1892, XXV, 49) because his observations remain as valuable contributions to the subject, and it is to the further publication of the experience of other physicians that we must look to reconcile discrepancies of observation and decide questions of pathology and prognosis.

(For the ensuing Discussion, see page 302).

REVIEW.

A SYSTEM OF GENITO-URINARY DISEASES.*

THE third and concluding part of Dr. Prince Morrow's "System" deals exclusively with Dermatology, and therefore merits a fuller notice at our hands than its predecessors. It comprises two imposing volumes of 470 and 506 pages respectively, and presents the same laudable features as the two first parts, one of which has been briefly noticed in our columns. The illustrations are numerous and almost invariably of great excellence, those coloured being produced by a process termed Coloritype, with which we are not familiar, but the results of which are sufficiently striking, if not always of great delicacy. Block-processes are employed for the reproduction of photographs, and, in many instances, with marked refinement and success, the selection of subjects illustrated in this manner clearly evidencing that the editor recognizes the narrow limitations of photography, employed alone, as representing morbid conditions of the skin.

The services of twenty-seven authors have been called into requisition, all of whom are well and favourably known in this country by their previous writings in the domain of Dermatology. Much of the matter is thus familiar, the writers having been naturally selected to undertake subjects of which they have made special study. One or two prominent names are absent from the list of contributors—to particularize which would be invidious—as in no instance can the work done be pronounced other than satisfactory, although various articles present various degrees of excellence. Indeed, these volumes constitute a monument to the zeal, ability and judgment of the strong band

* *A System of Genito-Urinary Diseases, Syphilology and Dermatology.* By various Authors. Part III, 2 Vols. Edited by Prince A. Morrow, A.M., M.D. (Edinburgh and London: Young J. Pentland, 1894.)

of our American fellow-workers. Throughout the work the bibliographic references are ample, without any claim for completeness being made upon the point, and a due sense of proportion is generally manifested in the amount of space allotted to the different subjects.

The opening chapter on the Anatomy and Physiology of the Skin, by Dr. Heitzman, is perhaps somewhat unnecessarily short, and might with advantage have been modelled more with a view to lead up to, or dovetail into, the subsequent descriptions of pathological changes and processes. The fault, however, is one inherent in a work compiled by various authors not always in close touch one with another. The whole tone of the chapter is, to our mind, somewhat old-fashioned, and we are surprised to find no special reference to the works of Unna—more especially to his classical contribution to Ziemssen's *Cyclopædia*. The same authority's method of section-staining, after hardening in alcohol, is dismissed in five lines as "misleading," and his views regarding the composition of the sweat are not referred to.

The chapters by the Editor on Semeiology and Classification are on the usual lines, but we are glad to note his departure from the purely objective standpoint of the Vienna school of twenty-five years ago, embodied in the sentence—"if the object were simply to recognize or name a particular disease, the signs visible upon the surface of the body are, as a rule, alone sufficient; but for the higher purpose of scientific therapeutics a knowledge of the nature and pathological relationship of the disease is necessary." We wonder why, in the discussion of Subjective symptoms, no mention is made of Hyperæsthesia or of Anæsthesia and their varieties, which we have a right to consider as of great symptomatic and diagnostic importance.

The system of Classification adopted is almost identical with that modified from Hebra's by Radcliffe-Crocker, but the Hyperæmias are—with reason, we think—grouped under the head of Inflammations, while the conditions due to pus-cocci are not differentiated into a separate class.

The description of the Exanthemata, by Dr. Graham of Toronto, occupies twenty-eight pages, in which they are considered in sufficient detail and with due authority, but we find no notice of the eruptions

of typhus and enteric fevers, beyond the fact mentioned in Dr. Hardaway's chapter on Etiology that they exist.

The chapters contributed by Dr. George T. Elliot exhibit specially praiseworthy qualities; they are intelligent in conception, modern in thought and expression, lucid in phraseology, and show a thorough, albeit discriminating, knowledge of recent work in all countries. Thus, in his consideration of the *Erythema multiforme scarlatiniforme* of Besnier, Féréol and Brocq, Dr. Elliot sees no reason for differentiation between a pyretic (*scarlatiniform*) and a pseudo-pyretic (*scarlatinoid*) form, pointing out (we consider with justice) that they are mere variants of the same condition, differing as to degrees of acuteness and length of duration, while the same ætiological factor may be responsible for both. Still less can Dr. Elliot see any reason for considering *Erythema scarlatiniforme* as a form, benign or otherwise, of *Pityriasis rubra*, but he insists upon its retention among the varieties of symptomatic *Erythema*. We cannot but think, however, that Dr. Elliot underrates the difficulty of determining a diagnosis of the disease which is, in this country at least, a rare one, and he does not mention the invariable tendency to relapse which alone has guided us to a proper conclusion in some of the few cases we have had occasion to observe.

We are not aware of any observations of Bazin's *Erythema induratum scrofulosorum* hailing from America,* where the disease is apparently rare, and this probably accounts for the slight stress laid upon necrosis and ulceration, which are at once among its most prominent and most misleading features. In the section which treats of *Erysipelas*—included along with *Erysipeloid* (Rosenbach), *Pellagra* and *Acrodynia* among the Inflammations and among the *Erythemata*—the condition which we are in the habit of miscalling "recurrent *erysipelas*" is summed up in a single paragraph (which is, however, a paragraph more than Radcliffe-Crocker or Malcolm Morris devotes to it), and it is interesting to note that Dr. Elliot has always found, contrary to our experience, some pre-existing morbid condition, among which he mentions "folliculitis of the vibrissæ." In the treatment of *erysipelas* he emphasizes the value of *ichthyol* as a local application, an opinion we can cordially endorse.

* Exception must be made for four cases reported by Professor J. C. White of Boston (*Trans. Amer. Derm. Assoc.*, 1894).

Dr. Elliot's handling of the subject of Dermatitis seborrholca is masterly, and although of course based upon Unna's almost universally accepted conception, it shows independence of judgment, justified by his having carefully studied no less than 1,400 cases of the affection. While sharing Unna's opinion that it is essentially an inflammatory change, and not a secretory disturbance from the first, he dissents from the view that fatty hypersecretion derived from the sweat-glands forms an integral part of the disease.

J. J. PRINGLE.

(To be continued.)

GERMAN DERMATOLOGICAL SOCIETY.

THE Fifth Congress of this Society will be held in Gratz (Styria), on September 23rd, 24th and 25th.

The chief subjects selected for discussion are "The present position of our knowledge of Pemphigus," introduced by Professor Kaposi and Dr. O. Rosenthal; and "The relationship of Tertiary Syphilis to treatment in the early period."

Numerous papers of interest will be contributed, and various excursions and social gatherings have been organized.

AMERICAN DERMATOLOGICAL ASSOCIATION.

THE Nineteenth Annual Meeting will be held in Montreal, Canada, on September 17th, 18th and 19th, under the presidency of Dr. Sherwell of Brooklyn.

A large number of specially interesting papers appear on the programme, which we regret not to be able to publish in full.

DERMATOLOGY AT THE MEETING OF THE BRITISH MEDICAL ASSOCIATION.

Held in London July 30th to August 3rd, 1895.

THE Sixty-third Annual Meeting of the British Medical Association, held in the Metropolis, is admitted on all sides and in every sense to have been brilliantly successful.

The section of Dermatology, which naturally interests readers of this Journal to a special degree, participated in the general success of the meeting, and indeed proved one of the most attractive and instructive of the sections, for not only were the dermatological *cognoscenti* from every city of importance in the United Kingdom well represented, but distinguished foreigners assisted, and took a lively interest in the proceedings. It was with especial pleasure that we noted the presence of numerous *confrères* in general practice whose prejudice against dermatology as being a mere exercise in inventing puzzles in nomenclature is obviously being slowly but surely overcome.

With great wisdom the whole of one day was devoted to the demonstration of living cases, and the only criticism which can be offered upon this part of the proceedings is, that it was too successful; for the eagerness displayed by the audience—or by such of them as were fortunate enough to secure good positions—was so intense that the cases were somewhat imperfectly seen by a considerable proportion of those present. The richness of material shown on this single day augurs well indeed for the success of similar practical demonstrations, which will form so prominent a feature of next year's International Congress, and which, we understand, will be held twice daily, in order to permit of a thorough examination of the cases, and of their consideration and discussion in appropriate detail.

The subjects selected by the Executive Council for general discussion appeared perhaps, at the first blush, somewhat lacking in interest, and incapable of being rendered attractive by those deputed to introduce them. One and all, however, of these gentlemen contrived to make excellent bricks with very little straw, and the debate upon the influence of diet in the ætiology and treatment of skin

diseases may be said with all justice to have reached a very high point of practical interest, if not of scientific import. No more convincing proof of the advance in rationalism in dermatology, as in other branches of medicine, could be adduced than the almost surprising unanimity with which by speaker after speaker the deleterious influence formerly attributed to all sorts of articles of diet in all sorts of cutaneous affections was negatived or scouted.

In Dr. Radcliffe-Crocker the section had secured an admirable president, whose criticisms upon every subject discussed were pregnant with interest, and bore the impress of extensive experience, scientific accuracy and practical acumen. He exercised his prerogative as chairman of the meetings with a laudable combination of courtesy and firmness, which latter quality was occasionally called for. Nor should the energy and thoughtfulness of the honorary secretaries, Dr. Stowers and Mr. Jonathan Hutchinson, Junior, in the organization and business of the meetings, be allowed to pass without an expression of the warmest approbation.

Wednesday, July 31st.

THE PRESIDENT, DR. RADCLIFFE-CROCKER, in his short opening address laid particular stress upon the great advances made in Dermatology during the past twenty years. This special branch of medicine was first represented at a meeting of the Association at the Dublin meeting sixteen years ago. Since then the section has firmly established itself as one of the most important and most successful. After referring to the great clinical opportunities existing in London for studying diseases of the skin, he expressed regret that, owing to the system of decentralization obtaining in the metropolis, visitors from the Continent were not as much impressed as they might be with the enormous amount of material available. He thought that the best interests of the section would be served by passing to the practical work of the day.

THE PATHOLOGY AND TREATMENT OF PRURITUS.

Professor McCall Anderson (Glasgow) opened this discussion, by reading a short and practical paper dealing, in the first instance, with the anatomical features of the skin and their relation to the feeling of itching, then with the usual conditions in which itching is

prominent, and finally with the treatment of this very troublesome symptom.

He was of opinion that the portions of the nervous apparatus of the skin specially concerned with the sensation of itching are as follows : (1) the free nerve terminations in the epidermis ; (2) the small groups of cells taking the form of a cup and connected with nerve filaments situated in the deeper layers of epidermis or upper layers of the true skin ; and (3) each hair, in virtue of the fine medullated nerve fibres which form a network in the outer coat of the hair and terminate in its sheath, is more or less of a tactile organ, and it is probable that irritation of the hair may cause pruritus. It is very difficult to say, however, why pruritus is such a prominent feature of some diseases of the skin and generally absent in others, such as the strumous affections ; how it is absent in the earlier and present in the later manifestations of syphilis—points to which he specially directed the attention of the section. He then spoke of some of the more prominent causes ; that which occurs in old age, and which he attributes to the circulation of impure blood ; that which occurs in connection with some cases of jaundice ; that which comes on in gouty persons and in connection with the functional derangement of internal organs, especially of the digestive organs ; that which occurs in diabetics ; that which occurs in connection with cold weather (*pruritus hiemalis*) ; and finally that which is dependent upon mental and not upon physical causes. From what he said it may be gathered that, without denying the influence of reflex irritation in the production of pruritus, he was of opinion that most cases are dependent upon direct irritation of the nerve terminations in the epidermis.

Before entering upon treatment he emphasized the importance of being quite sure of the diagnosis, eliminating all other disorders, such as urticaria, phthiriasis and scabies, in which the itching is but a symptom. Having done so we must make a careful examination of the patient in the light of its ætiological factors, and endeavour to correct any derangement which is found to exist. If the itching still persists, then the disease must be treated empirically. After referring to the subordinate importance of most local applications, and to the use of tincture of gelsemium and *cannabis indica* (Duhring), and carbolic acid (Hebra) internally, he expressed his preference for the employment of electricity, atropia subcutaneously, or the coal-tar

derivatives, such as antipyrin and phenacetin, in gradually increasing doses. If there is any suspicion of nervous or nutritive debility, nerve tonics, such as phosphorus, arsenic, or strychnia, alone or in combination, may be tried, the two latter preferably by subcutaneous injection.

Dr. H. G. BROOKE (Manchester) said that to make a complete study of the subject of pruritus in the short time at his disposal would be impossible, and that he would therefore limit himself to an examination of the various conditions under which the sensation of pruritus occurred. He used the term "pruritus" as meaning the sensation of itching generally, and not as confined to those particular forms which were unaccompanied by lesions of the skin. Recent French writers, especially Besnier and Brocq, used the old term *prurigo* in connection with all forms of disease in which itching was the primary feature, and deprecated the exclusive employment of the word to denote the one variety described by Hebra. The terms *pruritus* and *prurigo*, when unaccompanied by qualifying adjectives, ought no more to be used to denote special forms of disease, than words like *lichen* and *erythema*.

The sensation of itching varied enormously from a mere transitory titillation to a state of mad frenzy, in which the patient lost all self-control, and tore and scratched his skin with increasing fury until he at length gained relief. Bronson considered itching as a perversion of the sense of touch, a dysæsthesia of the nerve-endings in the skin, probably of those found by Pfitzner and Unna among the epithelial cells.

It was certain that epithelium was necessary to the production of the sensation of itching, for it did not occur in wounds until the epithelial covering was being reproduced. Bronson further made a most instructive comparison between the sensation and production of itching and that of the sexual orgasm. In the former the sense is co-extensive with that of touch and spread equally over the whole surface, while in the other it is confined to certain specially modified portions, but both are incited by friction, the one abnormally, the other normally, until a crisis of sensual excitement is brought about. The friction which is resorted to when the itching commences, is continued until the pleasant sensation is exhausted, or until scratching has produced pain, which is antithetic to every pruritus. It is a con-

version of a vague, weakly form of nerve-action into one of the more ordinary types.

Dr. Brooke then proceeded to detail briefly the different factors which were associated with the occurrence of the feeling of itching. For the sake of convenience he divided them into two main groups, according as they acted from within the body or from without, and these were each again subdivided into various sub-groups.

Internal Group—Neurotic.—(a) Purely nervous pruritus. The pruriginous diseases in which the pruritus is the primary disease have been laboriously studied by the French dermatologists, especially by Besnier, Brocq, Vidal and Leloir, under the name of *Névrodermites*. Reasons were given for objecting to the inclusion of some of the cases cited by these authors as examples of purely nervous pruritus, and for the probability that they were originally of local origin. But there was no doubt that the recognition of the peculiar papular, brown, or bistrous coloured, indurated state of the skin to which they applied the term “lichenification” or “lichenization,” as being a condition induced entirely by the action of long-continued scratching, was a distinct gain; it was entirely a secondary manifestation and not to be confused, as it hitherto had been, with different chronic eczematous and lichenous eruptions. All itching diseases did not lead to lichenification, even if of long continuance. Senile pruritus was always quoted as the arch-type of this “pruritus without prurigo” class, in which there was a characteristic absence of secondary lesions; but they were by no means always restricted to the aged, nor were they always distributed over the whole body. They might occur in younger people, even in infants, and they were at times restricted to some limited area of the body, such as the face, hands, tongue, anus and genitals. The great majority of the cases of anogenital pruritus did not belong to this class, but were of external (mostly seborrhœic) origin; nor did those which, although exhibiting no external lesions, were caused by the presence of irritable nerve-endings, the destruction of which removed the symptoms. In the purely neurotic cases the origin was more central, and required the complete destruction or ablation of the offending regions for their cure.

When lesions were present in conjunction with pruritus it was always important, from a practical point of view, to determine whether the

pruritus was primarily neurotic and the lesions secondary, or whether the pruritus was secondary to lesions arising from other causes. Among those of the former class were to be placed some varieties of eczematous eruptions, the "acute lichen simplex" of Vidal and Brocq, and that class of disease of which the prurigo of Hebra is the most clearly individualized type. Besnier has grouped all the various primarily neurotic itching diseases of this kind under the term "Diathetic Prurigos." Their first and always prevailing symptom is pruritus—pruritus which remits, recurs, exacerbates, which may come on insidiously and even in earliest infancy. The lesions which accompany them are never distinctive nor specific in character, but of an erythematous or lichenous kind at first, and, especially at the later stages, present some form of lichenization or eczematization in one or more of its varied manifestations. The diathesis may forsake the skin temporarily or finally, to reappear in the lungs as bronchitis or asthma, or in the nose as hay-fever, or sometimes in the gastro-intestinal tract; it may wear itself out by degrees and disappear finally, but in Besnier's opinion it is not amenable to any treatment. Dr. Brooke could not agree with this pessimistic prognosis, for he had found that much could be done to influence and even to effect the recovery of many of these, not very uncommon, forms of pruritus. The conditions were certainly more unfavourable when the disease was hereditary (or congenital), as was sometimes undoubtedly the case.

The essentially pruriginous group of papular, vesicular, or pemphigoid affections, known as *Hydroa herpetiforme* (Fox), or *Dermatitis herpetiformis* (Duhring), were usually of neurotic origin, although the influence of gastro-intestinal troubles and of certain foods in producing, or rather in precipitating, outbreaks showed that they were by no means exclusively so.

Urticaria, in like manner, although of very varied origin, might be of a purely neurotic character, and it was well known that a shock, or even a mere thought, might suffice to bring on an attack of wheals and itching.

Itching was also found as a preliminary symptom of some of the severer forms of nerve disease, and Leloir had described several of these prodrominal forms of pruritus under the name of *Dermatonévroses indicatrices*.

Lastly, there were the forms of itching which Crocker had designated *Pruritus mentis*, in which the patients suffered incessantly from severe itching, which they attributed to some purely imaginary ailment; this was really a form of monomania.

(b) *Reflex Nervous Pruritus*.—Reflex itching occurred at times almost to every one. A point on the skin was noticed to itch from no perceptible cause, and perhaps momentarily, and the sensation was immediately followed by itching at one or more points, often quite remote from the original point and from each other. It was merely interesting as showing the wide area over which even a slight and very limited pruritus may be reflected.

Pruritus which was caused secondarily by reflexes from internal organs, or from some kind of mechanical or chemical irritant was not uncommon. As instances were cited the itching which preceded or accompanied the development of serious intestinal or gastric disease, such as carcinoma, the itching which accompanied pregnancy and diseases of the uterus, the general itching caused by the presence of tapeworms in the intestines, that due to the action of gritty food (such as oatmeal), the itching at the end of the penis excited by stone in the bladder, and at the end of the nose by the irritation of ascarides in the rectum. The itching which was caused by the action of cold and heat on the skin came probably into this division, for, in the affections known as *Pruritus hiemalis* and *æstivalis*, it did not occur on parts of the body which were the most exposed to the heat and cold, but, and especially in the *pruritus hiemalis*, on well-protected regions, and even when the patient was still in bed, until tolerance of the frost had been established. The symmetrical *angeio-neuroses* which often accompanied winter pruritus also suggested the reflex rather than the direct action of the cold. Urticarial eruptions which had been excited by the action of cold to one part of the body might extend far beyond the original field of action, and develop reflexly a more or less widely dispersed pruritus.

2. *Hæmatic*.—A very frequent, distinct, and in the minor degree of development, not unfrequent class of pruritic cases, were those in which the itching was caused by the irritation of toxic substances which had been produced in the body and circulated in the blood current. The itching in diabetes, gout and lithæmia, rheumatism, kidney disease and jaundice were cited as examples. They were

often, but not invariably, accompanied by some *angeioneurotic* eruption, generally erythematous or urticarial in character. A similar condition was sometimes caused by fermentative processes taking place in the bowels, and was relieved by the administration of antiseptics. The urticarial pruritus of children was found to be very frequently associated with the presence of rachitis, and seemed to be the result in large measure, of the dilated stomach and consequent imperfect digestion which was so general in these cases.

The presence of irritating matter in the blood often *exaggerated* itching, which was due primarily to other, and often external causes; gouty conditions and imperfect action of the heart had *this* effect. Besnier thought that many cases of pruritus senilis were brought on by such states of the blood rather than by nerve degeneration.

Idiosyncrasy was always an essential factor in *hæmatic pruritus*, for only a small number of those who were the subjects of blood poisonings of these kinds showed any tendency to irritability of the skin.

3. *Foods and Drugs*.—The same remark also applied to the pruritus which sometimes followed the ingestion of certain foods, and the exhibition of certain medicines. Thus some people complained of a vague irritation of the skin after partaking of quite ordinary foods and drinks, *e.g.*, tea, coffee, alcohol, cheese, &c., while mercury, belladonna, and especially opium, were known to excite itching, often of a pronounced character in special patients. The presence of symmetrical erythematous and other lesions showed that the poisons might attack the nerve centres as well as their terminations.

4. *Mechanical Pressure*.—The itching of hæmorrhoids and of the genital region in cases of pregnancy, were apparently due to the pressure of the blood in the engorged venous plexuses, for it occurred apart from any skin lesion and disappeared when the pressure was removed.

5. *Abnormal Secretion of the Skin*.—The skin of otherwise healthy people was disposed to itch at times on account of its abnormal deficiency of lubrication. It had been attempted to explain this as the result of interference with the excretory functions, but the view that it was caused by the formation of minute fissures, and the partial exposure of the nerve terminations was more probable, for, although the relief derived from sudorifics would tally with both these

hypotheses, the relief which was given by simple lubricants, in limited patches of slight ichthyosis (which presented very similar conditions), gave stronger support to the latter explanation; and it was known that the healthy kidney very completely compensated any deficient action of the skin.

External Group.—The various external causes which give rise to pruritus were divided into three headings, viz.: (1) Local skin diseases; (2) Epizoid parasites; (3) Irritants of a physical and chemical nature; but it was found impossible to separate them out very clearly from each other. The first and most important point was to determine whether the itching was due entirely to the local lesion of the skin, or to some systemic condition. This was easy in such diseases as ichthyosis, but very much more difficult in affections like lichen planus, psoriasis, and certain seborrhœic and acute eczematous eruptions which might appear suddenly, and in people who were in other respects quite healthy. But whatever theories were held as to their causation, they were always treated as if they were due to a local excitant, and more reliance placed on local than on internal remedies. Acute eczema was one of the most prolific sources of pruritus, and many of the cases were of undoubtedly parasitic origin. The eruption generally spread because the system was debilitated and the sensory and vasomotor nerves in an easily excitable condition; but this state might supervene secondarily to the loss of rest caused by the incessant itching of one or two limited areas. It was known that the itching provoked by several substances, such as the poison of the *acarus scabiei*, of some of the primula species, and of iodoform might be transmitted in some individuals by absorption, or directly by the nails during scratching, over a wide surface of the body, and that it might give rise to typically eczematous rashes, and it was thus suggested that the extension of parasitic eczemas, or of eczema which had become parasitic (judging from their mode of extension), might, in like manner, be due to the transmission of infective substances by absorption or by scratching, over previously healthy areas of the skin. A knowledge of the possibility of such a mode of extension was a valuable aid in the treatment of some of these pruritic eruptions, and might help to explain why so many of our antipruritic remedies were of the disinfectant and bactericide class.

The itching, which was brought on by sudden changes of tempera-

ture, more especially by sudden exposure to cold, as when the patient rapidly undressed and got into bed, was perhaps due in part to the rapid removal of pressure from the skin, for it occurred in healthy skins; but in the case of inflamed lesions it was more probably attributable to the inability of the blood-vessels to accommodate themselves at once to the change, of blood pressure; it was, perhaps, by correcting this inequality that warm applications were able to relieve the pruritus so markedly. Change of posture from the upright to the recumbent position was also a well known provocative of itching, presumably also from alteration in the blood pressure in the direction of increased tension.

Except through the intermediation of some lesions such as dermatitis, chilblains, sudaminous and miliarial eruptions, heat and cold seldom produce itching by their direct action on the skin. The action of the actinic rays of the sun may set up intense pruritus, but it also was confined to the area of the lesions which they caused to appear, as in the urticaria which might start out after even a momentary exposure to the diffused light of a summer day, or in the papules and erythematous blotches of the prurigo æstivalis group of affections.

The pruritus which was caused by contact with certain drugs and plant poisons was often very severe, and its origin might easily escape notice, since any accompanying eruptions which might be present were seldom pathognomonic. It was, however, most important to investigate such cases, since they were generally due to an acquired idiosyncrasy towards some article of daily use. The action of rough underclothing was referred to as a common source of itching, even in merely irritable skins, and as a not unfrequent agent in the spreading of a local disease through the scratching to which they gave rise.

In most of the cases in which pruritus was present it was, it was true, but a symptom, but it was the symptom from which the patients were most desirous of being relieved, and it was for this symptom rather than for the disease that they sought the doctor's help.

DISCUSSION.

Dr. EDDOWES briefly referred to a case illustrative of "reflex" itching.

Dr. MYRTLE (Harrogate) strongly advocated the use of local applications in the treatment of Pruritus. In his experience the various preparations of coal-tar

were most valuable, especially when combined with chloral. In an obstinate case of pruritus ani marked relief had been obtained by the free use of a solution of potassa fusa in the strength of 15 to 45 grs. to the ounce.

Dr. WALDO (Clifton) recommended counter-irritation in the form of a blister or mustard-plaster over the vaso-motor centres of the affected part, as first introduced by Dr. Crocker for cases of symmetrical eczema of the extremities.

As an internal remedy sodium salicylate had proved frequently efficacious in his hands, and especially in pruritus associated with osteo-arthritis.

Dr. STOPFORD TAYLOR (Liverpool) had no faith in constitutional remedies. He pointed out the necessity for removing sources of local irritation. In Pruritus hiemalis, for example, the intensity of the itching can be greatly modified by avoidance of bathing. Again, in a now not infrequent form of pruritus, occurring in cyclists, and affecting the parts about the perinæum, the most important point of the treatment lies in protecting the surfaces from pressure or contact.

Mrs. GARRETT ANDERSON spoke of a neurotic form of pruritus met with commonly in women, or in men who lead effeminate lives, and due to malnutrition of the skin as a result of over-dainty feeding. The treatment for such cases is forced feeding and the administration of cod-liver oil. One must find out the particular foods which best agree with the patients, and induce them to take twice as much of it. Systematic rest is also important, and especially rest before food. Local irritation is to be avoided. Water is ill-borne. Silk underclothing should be substituted for flannel or other coarser forms of material.

Dr. BARENDT asked for further information upon the treatment of *pruritus sine prurigo*. In one case of universal pruritus without lesions the method adopted and found most useful was that of counter-irritation, obtained by an open blister in the lumbo-sacral region. He also strongly advocated the anointing of the limbs with warm olive oil, with a small percentage of carbolic acid. The oil should be rubbed in for five minutes, and in order to obtain satisfactory results it is necessary to insist that the operation be timed. Otherwise, the rubbing is usually continued for a much shorter period only. He had found this method of treatment more generally useful than any other known to him.

In replying, Dr. MCCALL ANDERSON agreed with Dr. Brooke that it would be well to get rid of the term pruritus as indicating a definite special disease independent of cutaneous lesion, and to regard such cases as merely examples of the symptom "itching." In the present state of our knowledge, however, such a term was often inevitable.

He would undoubtedly lay most stress upon constitutional treatment. But local treatment was often necessary to relieve the pruritus temporarily while the disease was being cured by internal remedies. Again, when the "itching habit" had been acquired, it was essential, in order to get a hold with internal remedies, to break off the "habit" for a time by means of local application.

He agreed with Mrs. Garrett Anderson that a lowering of tone was frequently responsible for the presence of itching, and that the careful treatment of this condition was, therefore, of the utmost importance.

Dr. LIDDELL (Harrogate) read a paper on A CASE OF PITYRIASIS RUBRA PILARIS, which is published in full at p. 279. He also showed microscopic sections from the case.

DISCUSSION.

Dr. ALLAN JAMIESON briefly referred to a case which had been under his care.

The PRESIDENT remarked that cases of *Pityriasis Rubra Pilaris* were extremely rare. No case had been recorded in this country since that of Tilbury Fox in 1878. The characters of the disease are so well marked that it is hardly possible that such cases can have been overlooked. Dr. Crocker had seen one case, and in this the papules were flatter than usual, and more markedly inflammatory. These features were most prominent at the lower part of the abdomen. It is probably owing to the presence of these flat papules that the disease has sometimes been confused with Lichen ruber acuminatus. A drawing of the President's case was shown at the meeting.

Dr. PYE-SMITH, F.R.S., read a paper on AFFECTIONS OF THE SKIN OCCURRING IN THE COURSE OF BRIGHT'S DISEASE, which is published in full at p. 284.

DISCUSSION.

The PRESIDENT did not take the same cheerful view with regard to the prognosis of these cases as Dr. Pye-Smith. Some patients recover from the eruption and live for long periods, but one should be careful always to give a guarded prognosis. In advanced Bright's disease with universal eruption the prognosis is always bad.

Dr. BRADBURY (Cambridge) concurred with the President's opinion, and asked Dr. Pye-Smith whether he regarded these eruptions as manifestations of uræmic poisoning.

Dr. SAVILL had noted the presence of albumen in the urine of five cases of epidemic skin disease, and each of these cases had proved fatal.

Dr. D'OYLY-GRANGE (Harrogate), after some remarks upon the "gouty" origin of these eruptions, drew attention to the variety of diseases produced by one poison, and thought that a more careful search should be made for this poison.

Dr. PYE-SMITH, in replying, said that he admitted no symptoms as "gouty" unless accompanied by characteristic gouty arthritic changes, and deprecated the employment of the term in any other sense. He was unable to consider these eruptions as uræmic manifestations, because uræmia is a very frequent condition, and these eruptions are exceptional. On the other hand, uræmia is not necessarily present when these eruptions exist. In reply to the President, he had seen many cases recover after the skin eruptions, and therefore did not attach to them a grave and fatal augury. The exfoliative form is rare, and he had only met with it twice. The general prognosis is naturally grave when a universal eruption is present.

Dr. PATRICK MANSON read a paper on SOME LITTLE UNDERSTOOD POINTS IN THE LIFE HISTORY OF GUINEA-WORM. After a brief description of the parasite—in which he showed that the mature worm (of which the female form only is known) consists mainly of a musculo-cutaneous cylinder enclosing a delicate uterus which, stuffed with millions of long-tailed embryos, extends from mouth to tail—he described the method by which this singular creature gets rid of her young, and he pointed out the reason for her preference for the feet and

ankles as the place from which to emerge. If by way of experiment, and in imitation of what occurs in guinea-worm countries under natural conditions, cold water be made to trickle on to the skin near a guinea-worm ulcer, and the minute hole at the centre of the ulcer be watched, one can see that very soon, in obedience to the stimulus of cold, a minute droplet of a whitish fluid wells up from the little hole, or that a delicate tube—the uterus of the worm—is protruded and ruptures. The parasite has no vagina at this late stage of her existence, and so she expels her young by causing prolapse of her uterus through her mouth. The fluid thus expelled is seen under the microscope to contain innumerable coiled up and passive guinea-worm embryos, which, on the addition of a little water, start into activity. If now some of these embryos are placed in a watch-glass with *cyclops quadricornis*, it will be found that after a few hours the young parasites have transferred themselves to the body cavity of the crustacean, where they undergo a metamorphosis. First they drop the swimming tail and transversely striated integument, a short conical stump taking the place of the long swimming tail, and the alimentary canal undergoing some degree of further development; later, a second moulting occurs and the parasite increases somewhat in size, the conical tail giving place to a sort of tripartite trephine-like stump. This is presumed to be the final stage of metamorphosis in cyclops, the guinea-worm being now ready for transference, in the cyclops and in drinking water, to the human stomach. Fedschenko found that in the warm climate of Turkestan the metamorphosis described was completed in thirty-five days; but Dr. Manson found that in the colder climate of England, and in English cyclops, it required a longer time—sixty to seventy days. These facts—which were fully illustrated by microscopical preparations, drawings, and some very beautiful and telling micro-photographs by Mr. Andrew Pringle—plainly indicate the way in which guinea-worm is acquired.

Dr. Manson pointed out that the rough-and-ready method of extracting guinea-worm by winding it out on a stick, regardless of the state of the uterus of the parasite, was unphysiological and very dangerous. Winding out should not be attempted until the parasite has emptied her uterus—generally in fourteen or fifteen days from the time she appeared on the surface of the skin. When she has emptied herself she tends to emerge spontaneously, and can then be easily and safely wound out. Dr. Manson thought well of

the newly-instituted treatment of guinea-worm by injecting her track with perchloride of mercury solution, 1 in 1,000; at all events, that it was worth an extended trial.

Dr. GALLOWAY read a paper on the "NATURE AND CAUSATION OF THE SKIN LESIONS OCCURRING IN NERVOUS DISEASE." He said that he would restrict his attention to the lesions occurring during the course of syringomyelus, as he had recently had opportunities of observing certain cases of the disease, and so had material to demonstrate to the section the lesions observed.

Five cases of the disease were then described, the principal points of interest in which are now narrated.

CASE I. was that of a man of 45 years of age, who has been under the author's observation during the past five years. He came first under observation on account of symptoms apparently unconnected with the disease, viz., the occurrence of fibromata over the body, one of which, occupying the floor of the mouth, was mistaken for a ranula. It was then observed that he suffered from considerable distortion of the spine, due to marked scoliosis accompanied by kyphosis. He had also loss of muscular power, associated with muscular atrophy, especially of the right hand—a condition which had gradually deprived him of power to work. In consequence of these lesions the sensation of the skin was carefully examined, with the result that well-marked *dis-*association of the modes of sensation was observed, affecting mainly the right side of the trunk and extremities. The sensations of ordinary contact, and apparently also of muscular sense, were intact on that side, while sensation to pain and to temperature were much diminished or obliterated. This peculiar sensory disturbance has progressed, but, as is to be expected, the whole right side is now more or less anæsthetic to all the modes of sensation, while the left side has shown similar changes.

During the years he has been under observation there has occurred also a passive cedema of his extremities, especially of the right side, so that the right hand is larger than normal, and the head seems too large for the body. An appearance of false acromegaly is in this way presented. At the same time the skin has become thick, rugose, and shows a tendency to ulcerate in parts. These ulcerations and occasional vesications seem in all cases, however, to be the result of mechanical or thermal injuries, as the anæsthetic condition of the

skin does not permit of his appreciating pain, heat or cold so as to avoid their results.

On more than one occasion he has suffered from painless whitlows, especially of the toes, and as a result occasional more widespread septic trouble. On one occasion while getting into bed he pulled off the nail of the right great toe without being conscious of the act, his attention being attracted by the fluid which escaped after the injury. Subsequent to this injury he had considerable septic lymphangitis of the right lower extremity.

This patient remains fairly well, but shows a gradual deterioration of both physical and mental health.

CASE II. was that of a woman whose history was partly recorded by Dr. Hughlings-Jackson in the *Lancet* (February 20th, 1892). This woman, now 50 years of age, shows in a most demonstrative manner the characteristic sensory disassociation on the right half of the head, neck and trunk, to the level of the tenth rib. Her right arm is scarred over—the results of burns and scalds which she had not appreciated at the time of infliction. A characteristic incident happened on one occasion that she consulted the writer. On attempting to remove her shawl it was found to be more firmly fixed than is usual. On investigating the reason it was found that the safety-pin used had been pushed through the skin of the right breast unknown to the patient. She has also a much enlarged and greatly disintegrated right elbow joint, the result of spinal arthropathy, and has much muscular atrophy of the right hand and forearm. Recently there has been some evidence of sensory changes on the left half of the body, and the speaker said that from other symptoms he suspected increasing degenerative changes in the spinal cord.

CASE III. occurred in a man of 45 years of age, who suffered from General Paralysis of the Insane with maniacal excitement. On post-mortem examination the typical lesion of the spinal cord was found, and it is possible that the occurrence of patches of analgesia or of altered sensation in the skin allowed, or perhaps caused, the numerous mutilations and injuries he inflicted on himself (*Trans. Path. Soc.*, March 17th, 1891).

CASE IV. was shown to the speaker by Dr. Hughlings-Jackson, and is typical of the many sensory disturbances that may occur during the course of the disease.

CASE V. was that of a young woman, a chronic epileptic with much muscular atrophy, who was brought into hospital burnt all over, having fallen into the fire during an epileptic seizure. At the subsequent examination the cord showed well-marked signs of the lesion in question (*Trans. Path. Soc.*, 1891).

Passing from the mention of these cases—the basis of his paper—the speaker described in order the lesions of the skin observed in syringomyelus, some of which were illustrated by the cases quoted, and summed them up as to causation under two heads.

1. *Faulty Nutrition of the Skin.*—As examples of this he especially mentioned the glossy skin so frequently observed, due to atrophy of the subcutaneous tissue and epithelium, and the opposite condition of hypertrophy, with its tendency to cracks, fissures and ulceration, so well seen in Case I. Affections of the nails corresponding to these conditions had also been described. Spontaneous gangrene of the skin was mentioned as a subject that had recently caused much attention, and which is occasionally seen in this disease; and the occurrence of certain varieties of perforating ulcer was also remarked on under this head.

2. *Irritative Central Lesions.*—The writer said that he retained this name for the case in description, although he intended subsequently to criticize it, and to advise its acceptance over a much more limited area than had hitherto been the case.

Under this name were included certain varieties of eczema, usually dry and desquamative in character, varieties of erythema and urticaria, and especially numerous vesicular eruptions of somewhat indefinite character. True herpes was a rare occurrence in the course of the disease, and in the majority of cases apparently had no immediate relation to it. The appearance also of transient localized cedema in various parts of the body was referred to, as well as abscesses, superficial or deep in character, and the whitlows that played so important a part in the type of the disease, described so graphically by Dr. Morvan (*Gazette hebdomadaire*, 1888, No. 35 *et seq.*).

Passing from the clinical features presented by this disease, Dr. Galloway proceeded to inquire if there were any pathological reasons to bring about the lesions described.

The main features of the morbid changes in the cord were first mentioned, and it was stated that in the vast majority of cases the condition was of embryonic origin, and might persist through life

without causing obvious, or at any rate serious, symptoms. The changes which cause the serious results in the disease were mainly degenerative in origin, and quite secondary to the embryonic defect. It was pointed out that the circumscribed character of the initial lesion and its consequent degenerative processes gave an excellent opportunity of locating morbid changes likely to produce the skin lesions mentioned.

In the first instance, in reference to the alterations in sensation, it was quite clear that a lesion having its main seat in the posterior columns and extending into the region of the posterior root-zone must naturally interfere with afferent nerves. But it became difficult to account for the peculiar incidence of the sensory disturbance—viz., that the sensations of contact and muscular sense were for long intact, while those of pain and temperature were early destroyed. The explanation suggested by Dr. Gowers, supported by the observation of the remarkable case quoted in his "Diseases of the Nervous System," depended on the wide anatomical separation of the paths of these two groups of sensory phenomena. It is suggested by this observer that the paths of contact, sensation and muscular sense ascend by the posterior columns, while those of pain and temperature are carried by the antero-lateral ascending fibres. Some such anatomical separation is, indeed, strongly supported by the sensory phenomena just quoted. But this hypothesis, to be proved, involves the establishment of the fact that the afferent fibres of pain and temperature, as they decussate, must be readily injured and destroyed by the lesion or its degenerative effects, soon after the initial symptoms are established; while the afferent paths of contact, sensation and muscular sense are not readily affected. Now, as decussation of these paths probably occurs in the posterior commissure for the most part, it is extremely improbable that one set should be uninjured while the other is destroyed, while both run the gauntlet of the lesion where its destructive effects are most likely to become developed.

It should also be borne in mind that the theory of anatomical disassociation of afferent paths, as described by Gowers, is not supported by experimental evidence. The early evidence that the paths of sensation are in the grey matter is corroborated by the recent researches of Dr. Mott, Dr. Aldren Turner and others, by whom it appears established that the afferent paths of sensation are in grey matter and probably in the *substantia gelatinosa* of Rolando or its

reality implied. It would appear, therefore, that the paths of contact and tactile sensation have much wider connection in the cord than those of pain and temperature, and are therefore more likely to survive any localized destructive lesion.

In the second place, the author remarked on the probability of vaso-motor disturbance, on account of the position of the lesion in the cord readily involving the masses of grey matter in which the cells controlling vaso-motor functions are located. This result is well established clinically, as the vaso-motor changes in the skin are numerous and characteristic, due both to irritation and paralysis of the centres.

In this place the speaker remarked on the changes which have been observed in the peripheral nerves, especially in Morvan's type of the disease (Jeffroy and Achard. *Arch. de Méd. expérimentale*, 1870-1875), and mentioned that many of the so-called trophic changes are really due to this nerve degeneration rather than to central nerve change.

Passing on, in the third place, to consider the rôle of central nerve changes in producing the skin lesions ascribed to them, the speaker said that he felt very doubtful if the numerous vesicular and bullous eruptions were really due to central irritation. It was remarkable how rarely the eruptions were of the type of true herpes, and how seldom symmetrical—if we exclude the extremities where special causes come into play. He felt much inclined to look on the various indefinite vesicular and bullous eruptions, including the lesions in Morvan's disease, as due to local causes, and especially to the action of pus-producing organisms existing either normally in the part, or introduced by accident, careless and dirty habits, &c. These, acting on an already weakened skin, due either to general malnutrition, or to special nerve changes, in his opinion brought about the majority of the eruptions of the vesiculo-bullous variety and the mutilations of the extremities so frequently described, and attributed to irritative changes in the central nervous system.

The paper was illustrated by lantern slides of various of the conditions described.

Dr. SAVILL asked how the presence of bullæ and pustules could be explained if they were regarded as due to local pus infection rather than to trophic nervous influence.

Dr. GALLOWAY, in reply, said that, owing to loss of sensation, the patients were more liable to local injuries, and that the growth of micro-organisms in the tissues was favoured by the loss of nervous control over the affected areas.

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DIET IN THE ETIOLOGY AND TREATMENT OF DISEASES OF THE SKIN.

BY WALTER G. SMITH, M.D.,

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Patrick Dunn's Hospital, Dublin.*

DR. ALLAN JAMIESON, in his careful paper, has dealt fully with the kinds of food which appear to have a tendency to induce individual skin diseases, and with the forms of cutaneous disease which may be considered to be influenced or caused by a particular dietary or by special elements in our food, and he has given us useful hints upon treatment.

The few remarks which I shall offer to you may be taken as complementary to his. I propose to dwell rather upon the limitations of our knowledge, and the imperfection of our data, in the hope that clearer views may emerge from our discussion.

Let me, in the first instance, ask, "Have we any certain or exact scientific knowledge of the influence of diet in the causation of diseases of the skin?"

The belief in the potency of this influence is universal with the laity, and widely acknowledged by the profession generally. But the practice of physicians is partly traditional, and is, unfortunately, not always based upon real conviction or sound knowledge, and many circumstances conspire to tempt them to give formal advice which rests upon a slender foundation. The present opportunity seems a

suitable time to re-examine the groundwork of our belief, and it may fairly be expected that the discussion to follow will result in a better definition of our position as medical advisers upon dietetics towards our clients—the public.

I start with the two propositions, that *the real influence of diet in the causation of skin diseases is a small one, much less than it is credited with*; and, that *our substantial knowledge of the subject is very limited*.

Fundamentally the action of food and of drugs is to be explained upon similar general principles.

But great as are the difficulties of forming a correct judgment of the mode of action of a drug, still greater are the complexities which surround questions of dietetics in the causation of cutaneous affections. We are always and in all places confronted with the problem of the idiosyncrasy of the individual, which is a real and perplexing difficulty, and should make us more cautious in formulating cut-and-dry rules for the guidance of our patients' stomachs.

In very many cases an intelligent and temperate patient knows, or ought to know, better than his doctor what suits him and what aggravates his complaint. And I heartily endorse Sir William Roberts' simple and sensible rule of conduct, viz. :—

"It may be regarded as certain that any food, or food-accessory, the use of which is followed by a sense of discomfort, is not beneficial to that individual." ("Dietetics," p. 106.)

And, conversely, as Pye-Smith puts it, "What most people eat is for most people wholesome, and what a natural appetite finds appetising seldom disagrees."

The tendency of modern inquiries has been largely towards the more exact determination of etiological factors. Hence we have been gradually led to minimise laying stress upon vague and indefinite conceptions, such as diatheses and the like, and of these vague causes diet is, I think, one, so far as the skin is concerned.

Moreover, the rise and progress of bacteriology has profoundly modified our notions of the cause of many diseases of the skin and influenced our treatment. I need only allude to the pathology of boils, carbuncles, and acute suppuration generally.

Although it is by no means proven that eczema, and even less, psoriasis, are parasitic diseases, still the mere ventilation of such a

possible cause for these affections tends to throw into the background loose speculations and traditional surmisings as to the effect of dietetic causes in originating diseases of the skin.

We may picture to ourselves four modes or ways, at least, in which diet may possibly influence the skin.

I. *Through the general nutrition of the body.* Nutrition is influenced in a very subtle manner by the quality of the food (Roberts), and insufficient or improper food lowers the tone of all the tissues, skin included.

Under such conditions we meet with scorbutic and purpuric affections. Destructive and pyogenic microbes find a more suitable soil whereon to fasten, and hence a greater liability to pustular and gangrenous developments.

The fungus of "thrush" lies in wait for debilitated constitutions, and favus is more common among the neglected and ill-fed poor.

II. *By acting as a reflex stimulus from the gastro-intestinal tract.* This is doubtless the most common mode.

The physiological relationship between the skin and the digestive mucous membrane is incontestable, and proofs are abundant.

Over-eating, on the one hand, and on the other, the use of unsuitable, indigestible, or irritating articles of diet are frequently followed by either neurotic or vaso-motor disturbance in the skin, *e.g.*, urticaria.

The skin affections producible in this way are all transitory, and disappear spontaneously, as a rule, when the causes cease to act.

Many people eat far too much and overload their digestive capacity. And some of them would pay a worse penalty than they do were it not for the dinner pill, the morning saline, or the occasional visit to Carlsbad.

Three practical considerations flow from these thoughts, viz., (a) The utility of purgatives in such cases. (b) The importance of good cookery in avoiding or overcoming dietetic irritation. (c) The due regulation of the diet as to quantity and kind.

III. *By absorption into the blood of irritating substances, or, of products of chemical change, which indirectly affect the skin.*

In this direction we may look for explanation, in part at least, of the occasional injurious effects of tinned and preserved foods.

Pathogenic bacteria may undoubtedly enter the body with articles of diet.

We are all familiar, by daily observation, with the hyperæmia of the skin which ensues upon full doses of alcohol.

IV. *The skin may suffer in virtue of being one of the channels or avenues of elimination.*

Certain drug eruptions, arising from volatile oils or oleo-resins, *e.g.*, copaiba, cubeba, and turpentine, are perhaps explicable upon this hypothesis. And, upon similar grounds, we caution our patients against the use of highly seasoned foods and spices (*i.e.*, volatile oils) in erythematous and acute inflammatory affections of the skin.

To turn now to another aspect of the question, *viz.*, diseases of the skin in relation to diet. We can at once make three groups:—

1. Cutaneous diseases liable to originate in, or acknowledged by common consent to be materially influenced by diet. 2. Cutaneous diseases possibly, but not proven to be, influenced by diet. 3. Cutaneous diseases certainly not affected by diet, *e.g.*, Herpes, Pemphigus, Lichen ruber, Ichthyosis, Ringworm, etc.

In class 1 we may instance:—(a) Erythema, certain forms of,—(b) Urticaria. (c) Pruritus. (d) Acne rosacea. (e) Acne vulgaris, perhaps?

Bulkley states that in some persons crops of acne follow the free use of buckwheat ("Eczema," 2nd Edition, page 291). And Pye-Smith affirms that in some patients a fresh outbreak of follicular inflammation can be produced at will by eating "crystallized" fruits, strawberry jam, or orange marmalade. (*Brit. Journ. of Dermat.*, July, 1895.)

In class 2 may be placed Psoriasis, most cases of Eczema, and of Acne vulgaris.

Eczema in children is very frequently attributed to dietetic influences, such as too free use of sugar, or even of milk. But, for my part, I quite concur with Dr. Cheadle in never having been able to satisfy myself that Eczema is a diet disease. (Cheadle, "Artificial Feeding of Infants," page 161.)

Many infants attacked with severe eczema are of a ruddy colour, have a good appetite, and with all the appearance of good health.

It is the present habit to ascribe many skin diseases to gout, and we hear every day of "gouty eczema," "gouty psoriasis," and the

like; and various queer nondescript ailments are shunted off the main line to a gout siding. Patients ask for and expect to get from us minute directions about their culinary arrangements. Yet few English practitioners, conversant with diseases of the skin, would go so far as Brocq in saying that the regulation of the diet is the most efficacious internal treatment for eczematous patients.

The hypothesis of leprosy having been transmitted by food of any kind, in particular by fish, has not been established by further examination.

Boils are often ascribed to errors or deficiencies in diet. With our present knowledge of the pathogeny of boils, it is, to my mind, incredible how a crop of boils, as is stated on good authority, can arise through mere change of diet, *e.g.*, a surplus of animal food.

In England the consumption of meat is 136 lbs. per head per annum. In France it is only 46 lbs. per head per annum. Are boils so much more common in England? Eczema affects the sexes almost equally, although men probably eat two-thirds of the total meat, and drink probably three-fourths of the total alcohol consumed in the United Kingdom.

If we direct our thoughts to determine what special articles in our dietary may be held responsible for harming the skin, we have not a long list, as will be gathered from the preceding remarks.

Coffee; tea, perhaps; highly spiced foods; excessive use of hard, salted meat; shell-fish; abuse of alcohol; and, foods such as starch and other carbohydrates, which may lead to the production of excess of acids (acetic, lactic, butyric) in the intestines.

A wide-spread and deeply-rooted custom is the strict prohibition of salted food in diseases of the skin. For many years I have ignored this dictum, and neither my patients nor myself have had reason to regret the liberty accorded to them.

Chloride of Sodium is a very harmless salt, and some people with a weak digestion or a jaded appetite will relish and easily digest a thin slice of ham when the stomach would revolt against other meat.

Does alcohol in moderation cause any skin affection? That it is apt to aggravate itching and increase an already existing congestion of the skin is quite true.

Most of the Asiatic populations, with the exception of the Japanese and the Indian Parsees, drink no alcohol. Yet I do not know that this

experiment, on the large scale, indicates any advantage to those races *quoad* the skin.

I cannot but believe that the ill effects of alcohol, and I may add of tobacco, are exaggerated by their extreme opponents, at any rate, as regards the skin.

Plenck (quoted by Bulkley) remarks of acne, "*Plures curavi suadendo, ut vinum bibere incipiant.*"

Lastly, a word as to the practical outcome of all this.

How are we to intelligently answer the questions so often addressed to everyone of us by our clients, "What shall I eat?" "What shall I drink?"

In such cases as diabetes, gastric ulcer, and enteric fever there is a tolerable degree of unanimity in our answers.

But what about the slighter ailments and indispositions which constitute the bulk of our practice?

A large number of our patients with affections of the skin are not obviously out of health, and are well able for their day's work in the world. Yet these persons are apt to ponder over their health, put us through a catechism as to their diet, almost constrain us to go beyond our knowledge, and even glory in the dietetic chains which are fastened around them by their medical advisers.

Unluckily it sometimes happens that one practitioner's rules *flatly* contradict those of his neighbour, and so a shrewd patient is liable to arrive at the unpleasant conclusion that, as Sir William Roberts puts it, our notions on dietetics are little better than a farrago of whims and fancies.

We are too formal in our rules, and impose unnecessary and unmeaning restrictions. We prescribe diet by printed forms, making no allowance for idiosyncrasies, and giving even our educated patients little or no latitude or opportunity for exercising their own sense of what is good and what is bad for them.

In my judgment the main precept we need enjoin as a golden rule upon our patients suffering from diseases of the skin is moderation and temperance in all matters of eating and drinking, and especially as regards alcohol.

And we should seek to train the public to observe for themselves whether such and such an item of diet really agrees with them or not.

With all this borne in mind there is plenty of room for judicious

advice tempered with common sense, and a hint or a suggestion is often better, although less showy, than the imposition of conventional rules. This latter course is, no doubt, sometimes requisite with the hypochondriac, the sensualist, or the careless, who will not listen to, or are incapable of understanding, the still small voice of healthy instincts and of personal experience.

To sum up in a few words:—

1. Very few skin diseases are directly traceable to dietetic causes, but improper diet may aggravate existing eruptions. Idiosyncrasy must be largely allowed for.

2. The diseases that may so arise are of a transitory character, and mostly belong to the class of erythemata.

3. Diet has very little influence in promoting the cure of cutaneous eruptions. The results are far behind popular expectations, even in such cases as acne rosacea, where we are led to hope for much.

4. Avoidance of alcohol, regulation of the bowels, and the cure of anæmia are of infinitely greater importance than special dieting in the management of diseases of the skin.

I may add that I have discussed this matter with my friend Dr. Wallace Beatty, and these propositions represent our joint views.

(For the ensuing Debate see page 330.)

A CASE OF ADENOMA SEBACEUM INTERMINGLED WITH MOLLUSCA FIBROSA.

BY WILLIAM ANDERSON, F.R.C.S.,

Surgeon to St. Thomas's Hospital.

(Read before the British Medical Association, August 2nd, 1895.)

THIS case falls into line with the interesting series collected by Dr. Pringle a few years ago.* As it occurred in a male subject, however, it tends to equalize the sexes, and it is distinguished from most of the recorded instances by its non-congenital origin, by the absence of any associated teleangiectasis or dyspepsia, and by the fact that the patient's intellectual condition was quite up to the average level, although he suffered from a deafness that was unaccompanied by any evidence of coarse disease of the auditory apparatus, and might have been of central or nervous origin. Like Mons. Vidal's case, it was complicated by the presence of mollusca fibrosa on other parts of the body, and, as in some others, the "Adenoma" resisted all treatment during their term of active growth, but became arrested spontaneously when the developmental period came to an end—at about the age of 25.

The notes of the case are as follows :—

The patient, an agricultural labourer, aged 27, was admitted into St. Thomas's Hospital in March last with an eruption upon the face and trunk.

He was a man of fair physical development and of good intelligence, but very deaf. His general health had always been good, and his family history was negative. He says that his skin was normal until he reached the age of 7, when a few spots appeared on each side of the nose ; these spread over the face, and a year or two later small growths were noticed upon the body. At the age of 14 he became deaf without obvious cause, and without any visible disease in the ear. The skin lesion progressed steadily in spite of treatment,

* *Brit. Journal of Dermatology*, January, 1890.

until about a year ago, when it seemed to become stationary, but no improvement has taken place.

On admission an eruption of papules covered the greater part of the face. They consisted of lenticular and acuminate spots, from about the size of a millet-seed to that of a tare, and varying in colour from a pale rose to a brick red. They were most abundant below the level of the orbits, and most thickly set and vascular over the rosacea area, forming broad bands along the cheeks and chin in the neighbourhood of the nasolabial and labiomental furrows. There was no teleangiectasis between the lesions.

On the trunk was an eruption of papular elevations of the normal colour of the skin, and numerous raised irregular patches of half an inch to an inch in diameter, apparently due to a fusion of the smaller papules; and intermingled with these were numerous small flaccid mollusca fibrosa, sessile and pedunculated. There was no pruritus in connection with any of the lesions.

The disfigurement caused by the facial eruption gave much distress to the man, and to improve his appearance it was decided to excise the more conspicuous groups. This was effected by including each of the patches between two incisions extending through the cutis and following the direction of the normal expression lines. The diseased area was then excised, and the edges of the wound were brought together by subcuticular sutures of catgut. The large aggregations having so been disposed of, most of the small outlying papules were shaven off. The surface was then dressed with iodoform and collodion.

The wounds healed by first intention under the film, and when at the end of a week the dressings were removed the appearance of the patient was greatly improved. The scars were linear, and so far coincided with the nasolabial and labiomental furrows that they were little noticeable. The loss of tissue, moreover, had caused a narrowing of the previously somewhat heavy jawl, that gave a better outline to the face. Many outlying spots still remained, and it was proposed to deal with these by a subsequent operation, but the patient was compelled to leave the hospital in obedience to a summons from his employer. He has, however, promised to return, and was expected to arrive yesterday, but his employment has unfortunately prevented him from attending in time to present himself at the meeting.

A microscopical examination of the excised structures revealed appearances like those described in the cases already recorded. The chief interest of the case, apart from the addition of a fresh item to the still scanty record, lies in the treatment adopted—that of excision. The plan is of course not feasible in many examples, but where it can be carried out, it affords some relief to a disfigurement that has hitherto resisted every remedy, local or general.

It is difficult to speculate as to the origin of the disease. It is of course quite different structurally from the acne group, but its distribution coincides to some extent with the area of acne rosacea, and its period of active development has nearly the same limits as that of acne vulgaris. Unlike most other new growths in the skin, it tends to undergo spontaneous arrest, but it shares with these the rebellion to external applications.

(The ensuing Discussion will be found on page 331.)

A CASE OF CHEIRO-POMPHOLYX.

BY FRANK H. BARENDT, M.D. LOND., F.R.C.S. ENG.,

*Physician to St. George's Hospital for Diseases of the Skin, Liverpool;
Pathologist to the Royal Southern Hospital, Liverpool.*

To the dermatologist, localized bullous eruptions are especially interesting from a clinical, as well as from a pathological point of view. In studying their evolution, passing, as they do, now rapidly, now sluggishly, through the macular, papular and exudative stages, we are impressed by the relationship that subsists between such bullous eruptions and those affections first typified and described by the Nestor of dermatology—the late Ferdinand Hebra—under the name of *Erythema exsudativum multiforme*.

The case that I am about to describe, clinically as well as pathologically supports this impression. It was only when the final stage of development had been reached that the diagnosis of Cheiro-pompholyx could be made with certainty, and thus receive, if I may say so, the official imprimatur that it was an affection already known to, and described by, dermatologists. In fact, the disease at first looked like an example of *Erythema exsudativum multiforme*, and were we to

regard it simply from an anatomical standpoint, the conclusion arrived at would be, that the difference was due to the more abundant exudate which had caused the appearance of vesicles and blebs. The blebs were most marked where the skin was lax, and therefore offered least resistance to their formation.

As regards the amount of exudate present, it has, as far as the study of inflammation tells us, no deciding value in respect to the ætiology of either bullous or erythematous affections. Clinically, we are correct in keeping apart the erythemata, as such, from the bullous eruptions attacking the same skin areæ—if for no other reasons than the striking macroscopic differences. But when the question of ætiology arises, we are constrained to admit their close connection, whether we accept a toxic or a neurotic theory to account for the clinical appearances. As a matter of fact we have no data to go upon whether a given erythema-papule is likely to remain so, or give place to a bulla, and it is well known that in many recurrent attacks of Erythema multiforme, vesicles and bullæ are by no means infrequent, scattered among the rosy-red papules, and which plainly represent a more advanced stage of the inflammatory process. I have accentuated this connection in the hope that others here present whose experience is greater than mine may be able to explain whether, for instance, when bullæ predominate, the neurotic factor is more pronounced, and when papules the rheumatic, *i.e.*, toxic, factor is more *en évidence*, or contrariwise. The case of Cheiro-pompholyx rather supports the view that it is a neurotrophic lesion. The following are in brief the particulars of the case :—

F. H., female, ætat. 36, married, came under my care at St. George's Hospital for Diseases of the Skin, Liverpool, on the 1st July, 1895, complaining of great burning, soreness, and itchiness in the fingers, especially those of the left hand. She noticed it first four days previously, and thought she was going to have an attack of sick-headache, to which she is subject. The irritation and discomfort were so great that at night she could not sleep, but had to get up and plunge her hands into water. The patient is a slim-built woman of a melancholy type, and states that she suffers constantly from sick-headache; these attacks of megrim are frequently ushered in by tingling of the hands, teichopsia, giddiness, and great depression of spirits and confusion of thought. The headache starts usually on the

left side, spreading all over the head. The attack generally ends with vomiting. She is always costive, and has to take pills regularly. She has never had any skin eruption before, and cannot account for her fingers being in their present condition. Latterly she has not been having good food. Three months ago she was confined of her third child, all three being well and free from skin trouble. It was then she received a severe shock in the death of her husband at sea, and to this, coupled with poor nourishment, she attributes the condition of her hands. Her family history sheds no light upon the skin trouble. There is no history or personal evidence of rheumatism, gout, syphilis, and none of alcoholism or any other toxic agent. Examination of the thoracic organs revealed nothing abnormal, her eyesight and hearing were good, there was no gastric disturbance, and the urine was free from albumen.

She never suffered from clammy hands, nor were her hands drier than other persons'; she had not been using any application to them that could account for their condition; she fancied that plunging them into cold water might have brought out the rash.

On inspection the palmar surface of the fingers, extending to the roots, and the thenar and hypothenar regions, as well as the dorsal surface of the median and ungual phalanges, and opposing digital skin-regions of both hands, were studded with raised red patches. They were discrete, varying in size from a pea to a threepenny-bit. The largest plaques were on the dorsal surface of the digits, the smallest distributed along the inner opposing skin areas of the fingers. The eruption also implicated the web of the fingers, especially between the thumb and the index. The hollow of both palms as well as the metacarpal regions and dorsal aspect of proximal phalanges were free from efflorescences. The digits were distinctly swollen, the finger pulps especially pained her on manipulation, and she could not "make a fist." There was no tenderness over the ulnar, median or musculo-spiral nerves; the nails were not affected. The feet were quite free and the mucosæ of the various orifices were not implicated: this is an important point.

She was ordered to keep her hands out of water, to bathe them with hot olive-oil night and morning, and to apply a zinc paste consisting of equal parts of oxide of zinc, starch, vaseline, and lanolin, and keep them gloved. For the constipation equal parts of Infus gent. co. and Mist. sennæ co. were prescribed.

A week later, *i.e.*, July 8th, the irritation, although present, was more bearable, but the soreness was increased, the plaques and papules were still more raised and swollen, the outline of the digits club-like, and dorsal surface showed the swollen area to be confluent, while the skin was tense and shining. The bowels being still troublesome, for Infus. gentian co., Decoct. aloes co. was substituted, and Lotio calaminæ was ordered to be applied locally.

On July 11th, *i.e.*, three days later, and fourteen days after she noticed the first symptoms, her hands presented bullæ and vesicles in the sites previously occupied by the red-raised plaques. The bullæ were seen chiefly on the dorsal surface, where the skin, being lax, offered least resistance to the exudate, and here the walls of the blebs were thinnest. Bounding the interdigital spaces were clusters of distinct vesicles, like semolina grains. Some of these were quite superficial and exuded a turbid fluid. The pulps of the fingers as well as the clefts showed distinct bullæ. The hands looked as if they had been scalded and blisters were the result. Owing to her inability to attend to herself she was now admitted into the Royal Southern Hospital under the care of Dr. Cameron, who kindly allowed me to watch the further progress of the case. No further eruption took place, the bullæ were opened, the smaller vesicles gradually became absorbed, and the upper layers of epidermis were becoming loose, not only where the rash was, but where the skin was apparently sound.

On July 29th I saw the patient last. Her general appearance was much improved, she was brighter and not at all dejected. The skin of the palmar surface of the digits was smooth, red, and a little tender to the touch; here and there were to be seen the remains of dead epidermis in process of exfoliation. There was no weeping surface, and no recurrence of the eruption. The feet and mucosæ, as I have already said, were not affected.

Pompholyx may attack the feet alone—podo-pompholyx; and recently I have had a case of this disease under my care. The patient, who came from Paris, had consulted Mons. E. Besnier, who termed it *Dermite sudorale*. The eruption was distinctly bullous, but more discrete than in the above case. It was developed on the plantar aspect of the toes, the cushion of the foot and heel; a few scattered blebs were also to be seen on the instep. The left foot was worse

than the right; the patient was left-footed and addicted to wearing too tight boots. As regards its causation, he averred he never suffered from perspiring feet, nor had he ever suffered any discomfort. On the other hand, he was distinctly a nervous man, and at times suffered from headache.

I have drawn attention to the absence of any implication of the mucosæ of the orifices. I have more than once seen eruptions, partially bullous, attacking hands and feet, and implicating the mouth, anus and prepuce; and I believe such an association is by no means uncommon.

As regards this case of Cheiro-pompholyx, the question naturally arises, what is the cause of the complaint? Tilbury Fox described a bullous affection caused by a disordered function of the sweat-glands, and termed it, therefore, dysidrosis. There was, however, no history of hyperidrosis or any derangement of the secretory glands. Jonathan Hutchinson, to whom we are indebted for the term Cheiro-pompholyx, does not regard it as a sweat disorder, and our distinguished President terms the affection simply pompholyx, thus avoiding any term that might connote a pathological theory as yet unproven.

I could not detect any external or internal exciting cause for the affection; she had not been taking any medicine whatever, and her diet, although insufficient, could not account for it. On the other hand, she suffered considerably from headache, had recently experienced a great nervous shock, and is by nature a nervous, high-strung woman. But why the vaso-motor nerves regulating the calibre of the digital arteries which supplied the skin area in which the eruption was, should be singled out, and the *materies morbi* (or whatever it may be), expressed in the fingers, are problems which I have been unable to solve. That Cheiro-pompholyx is a neurosis—*i.e.*, a disturbance of the digital vaso-motor nerves—we must admit, and the presence of other well-known neuroses occurring in such patients lends support to this view. Whether this view helps us much ætiologically, is open to doubt, for what we wish to know is the agent which produces this disturbed function.

REVIEW.

A SYSTEM OF GENITO-URINARY DISEASES.*

(Continued.)

DR. STELWAGON treats of impetigo, impetigo contagiosa, and ecthyma as different diseases, and although we are aware of his authorities for doing so, we cannot but disagree with him on the point, both on pathological and clinical grounds. His article on dermatitis herpetiformis is excellent, and the differentiation of the disease from pemphigus is sufficiently clearly established to convince even the most conservative adherents of the older Vienna views.

Dr. Zeisler, on the contrary, in his article on pemphigus, questions "whether much is gained by separating different forms of pemphigoid eruptions from pemphigus and simply shifting them over to that all-embracing disease of Dühring." The same writer in his article on prurigo lodges a strong protest also against the dethronement of Hebra's conception of the disease and its classification along with papular eczema, urticaria and pruritus, or as a member of the lichen group, as urged more particularly by Vidal and Brocq.

Dr. Piffard's interesting views on eczema, its ætiology and its management, are well-known, and are here reiterated. It will suffice to state that we consider them very open to argument. He describes an eczema of the sebaceous glands as apart from eczema seborrhœicum, which we do not recognize. For the cure of the lesions of eczema, in contradistinction to the constitutional conditions which precede, underlie or accompany them, Dr. Piffard still chiefly relies on the drugs arsenic, calx sulphurata, and viola tricolor. We imagine that in these views Dr. Piffard stands alone, or nearly so. To the local application of a strong solution of the peroxide of hydrogen in ether are attributed "almost magical" effects in reducing purulent exudation and hastening the formation of new epidermis.

* *A System of Genito-Urinary Diseases, Syphilology and Dermatology.* By various Authors. Part III, 2 Vols. Edited by Prince A. Morrow, A.M., M.D. (Edinburgh and London: Young J. Pentland, 1894.)

In the discussion of the treatment of the local varieties of eczema there are many useful hints, which disclose a large amount of experience and observation.

In Dr. Corlett's otherwise excellent article on psoriasis we note no reference to the vexed question of the relationship of seborrhoea to the disease, nor to the tendency in certain cases to the supervention of exfoliative dermatitis, which we regard as one of the main points in determining their prognosis. The same author discusses pityriasis rosea. We gather that he has not observed for himself the "primitive plaque," and we must demur to the statement that in England the disease had received but little attention. Dr. Corlett also writes separate articles on dermatitis exfoliativa and pityriasis rubra, regarding them as separate diseases; but as no allusion is made to Brocq's masterly and well-known summary of our knowledge on the subject, the articles must be regarded as imperfect.

Again, Dr. G. H. Fox's articles on lichen ruber and lichen planus, able as they undoubtedly are, betray such an indifference to opinions generally entertained since the Paris Congress of 1889 that we can only suppose that the Transactions of that Congress and much subsequent literature have not been perused by the writer. Two very beautiful block reproductions of photographs of exquisite examples of pityriasis rubra pilaris—although called lichen ruber papulosus—and of lichen ruber moniliformis, render the chapter of value.

The Editor is on sure ground when treating of drug eruptions, and the somewhat pedantically named dermatitis venenata, while his article on leprosy is thoroughly admirable, although disfigured, to our mind, by the theatrical introduction of a likeness of the late Father Damien, the features of whose "case" were of no special scientific interest.

The various clinical expressions of tuberculosis of the skin are admirably handled by Dr. Bowen, but a fuller description of tuberculous ulceration of mucous membranes would be well within the limits of the article, which might also with advantage include the diseases generally termed "lichen" and "acne" scrofulosorum, if not also Bazin's erythema induratum. The treatment of all the affections included in the group might be elaborated with advantage, and more precise indications given for the employment of the various applications recommended. We are glad that Dr. Bowen is not led

astray by the eloquent pleading of Besnier to consider lupus erythematosus as a form of tuberculosis of the skin ; but we look in vain for the name of Hutchinson, upon whom the theory ought in justice to be "fathered."

The greater part of Volume III. calls for little comment, as containing less matter that is contentious. The question of the psoropermial origin of various skin diseases might have been discussed with greater firmness, but Dr. Hartzell blows both hot and cold on Darier's views, leaving us in doubt as to his own opinions. Dr. Fordyce expresses himself in somewhat clearer tones in favour of the parasitic origin of epithelioma, his contributions upon which, as well as upon carcinoma and sarcoma, are very satisfactory.

The chapter upon sensory and sensory-motor neuroses by Dr. Bronson is one of the best in the book, and a special word of praise must be accorded to Dr. Pollitzer for his excellent description of diseases of the sweat-glands, which constitutes the most exhaustive compendium extant of our knowledge of the subject, in a comparatively limited space.

In addition to many "Americanisms" of expression, which add piquancy to the text, there are occasionally evidences of editorial haste in slips in spelling, *e.g.*, Filiaria, Lanonlin, Lambroso, Willson, and such words as "psoriatiform" and "motory" seem unnecessary and ugly. It would also be well to revise much of the Latin, which includes such barbarisms as hydroa bullosus, sal soda, cutis tenea, lichen rubra, &c., while the spelling throughout of the word scleræma (for sclerema) shows an entire misconception of its derivation ; and additional instances of imperfect appreciation of the classical languages might be adduced.

But a work of such magnitude naturally presents much material for criticism, and it would be a poor compliment indeed to review it in the customary platitudinous terms of fulsome, indiscriminate praise. We have ventured to indicate many points which seem to us erroneous or dubious ; but regarding the work as a whole, we have no hesitation in recommending it warmly not only to all who take a special interest in Dermatology, but also to the general practitioner, who will find it a handy, comprehensive, practical, and, on the whole, reliable guide to diagnosis and treatment of diseases of the skin.

J. J. PRINGLE.

DERMATOLOGY AT THE MEETING OF THE BRITISH
MEDICAL ASSOCIATION.

Held in London July 31st to August 4th, 1895.

Wednesday, July 31st.

Dr. HARRISON (Clifton) read a short paper on *Two Unusual Cases of Verruca Necrogenica*.

This disease seems always to be associated with the handling of dead flesh—animal or human—and the unusual element in the two cases brought forward, is that the victims have never had to do with the above cause. One, T. B., is a commercial traveller in the cloth trade; and the other, M. M., is a packer at a warehouseman's stores, and has had to do with sugar-casks, rum, wine, and cotton goods.

T. B. has always had good health, and the family history is very good, while his habits are active and healthy, although occasionally he may have indulged in a little more whiskey than was good for him. The complaint commenced as a small papule at the end of the right thumb, close by the nail, which was first noticed on Bank Holiday, in August, 1891. It increased in size very gradually, and threatened to invade the tissues under the nail; but not finding this a very congenial soil (for the nail and its matrix never became really involved), it spread slowly down the ulnar side of the thumb, and when seen by the speaker was a papillomatous warty-looking mass, with a reddened border, which extended beyond the limits of the growth, and occupied the lower part of the structures beside the nail and the adjacent half of the lunula, whilst the part first attacked had almost assumed its natural appearance except for slight shrinkage, rather than scarring of the surface. At times the growth would become hot, irritable, and rather painful, and then a discharge of a little muco-purulent fluid would relieve the symptoms, followed by a varying period of quiescence. This condition of things continued for some time, and the disease spread down the side and part of the nail,

and was so little influenced by treatment with salicylic acid, ammoniated mercury, nitrate of silver (stick), &c., that in May, 1894, it was determined to remove the affected parts with the knife, and then apply nitrate of mercury, and dress with pyrogallic ointment (5 per cent.), afterwards. This treatment was altogether so successful that in a few weeks the parts were healed; and a photograph taken quite recently (which was exhibited, and contrasted with an earlier one before any operative interference) shows that, except for a slight shrinkage of the parts, and the loss of the nail (which was removed, and did not grow again, although the matrix was not affected by the disease), there is none of the mischief left.

Microscopical examination of the hardened tissues showed remains of ulceration, hyperplasia of the horny layers, and thickening of the blood-vessels, but no bacilli of tubercle. At any rate, none could be found.

The second case, M. M., a man aged 52, came under Dr. Harrison's care in February this year, and when first seen the parts presented the appearances shown in photograph, by which it will be noticed that there is a papillomatous growth extending from the metacarpophalangeal joint of the right thumb upwards (when the hand is prone) towards the metacarpal bone of the index-finger, and then curving round and downwards as far as the carpal joint of thumb, leaving about a third of the circle unmolested. The appearance is very similar to the first case, a redness extending beyond the line of the growth, and leaving the central portion unaffected. The part is hot and irritable at times, and then remains for varying lengths of time quiescent.

Two years previously he had pricked the ball of the thumb deeply on a rusty nail in a sugar-cask. The wound bled much at the time, and healed up very slowly. Then a single scab formed upon it, and in two months afterwards the roughness went off on the injured spot; but it gradually extended upwards towards the thumb-joint, and spread as above described.

In May the man was admitted into the Bristol General Hospital, the parts removed by careful dissection, and the wound treated antiseptically. In about a month it had healed, and except for a slight scaliness looks now quite well, and the man is able to resume his work.

His family history is very good. His father and mother were

healthy people, and lived to about sixty years of age, and he has sisters married, whose children are all healthy.

Microscopical examination showed the same condition of things as in the first case, but there were well-marked giant-cells, and appearances of tubercle; very careful research revealed, however, no bacilli of tubercle.

Now, if these two cases are to be called *Verruca Necrogenica*, it is clear that we must look for infecting agents other than dead flesh alone. It may turn out eventually that these and similar cases are merely forms of lupus, and *Verrucosus* would be the term that most appropriately might be applied.

The PRESIDENT pointed out that tubercle bacilli were difficult to find in these cases, and their non-discovery did not prove their absence. *Lupus verrucosus* and *Verruca Necrogenica* are now regarded as one and the same disease. In regard to the question of treatment, excision is not always necessary. Very good results are obtained by softening and partially removing the warty growth by salicylic acid, and destroying the remainder by the application of fuming acid nitrate of mercury. This treatment naturally covers a longer period than that of excision, but the results are in every way as satisfactory.

Thursday, August 1st.

DIET IN THE ETIOLOGY AND TREATMENT OF DISEASES OF THE SKIN.

Dr. W. ALLAN JAMIESON (Edinburgh), in introducing the subject, observed that it naturally divided itself into two parts, the first of which was the influence of food in causing or maintaining cutaneous diseases. There were at the outset certain limitations to the field of observation. One of these is the relative frequency of the ailment; it is impossible to estimate the effect of diet in the case of rare affections. In the case of some chronic disorders we possess no information, and in acute diseases there is no time afforded. Some data are available with regard to eczema, assuming this to mean a catarrhal process—hyperidrosis, acne, dermatitis herpetiformis, lichen, alopecia areata, psoriasis, lupus, epithelioma, and sarcoma. The statements volunteered or elicited from our patients are confusing, or unreliable, in many cases. It is difficult, too, to fix on the disturbing element in a mixed dietary, while the environment and habits exert an occult influence. Some articles of diet have a toxic or dynamic power. An

example is urticaria, but idiosyncrasy comes into play. In most cases the action is a remote one, and is predisposing, there being some directly exciting cause. An instance of this is pellagra. There are but few special articles of food or drink which can be individually accused. Alcohol abused induces in some local hyperidrosis, vascular dilatation, and rosacea. Tea causes cold hands and feet, and shrinkage and withering of the integument. The persistent omission of fresh vegetables from the dietary leads to various degrees of the scorbutic diathesis, though it is surprising how long the system can hold out. The patient may not appear anæmic, yet his eczema may be largely due to this defect. In many of the sufferers from eczema the diet is wanting in fatty material, or the adipose deposit in the body is derived from sugar or starches, and is poor in quality. The amount of water ingested may be insufficient to flush the renal tubules, or the meals are too closely crowded together, or are too widely separated. Hurry in partaking of meals is a cause. Irregularity and haste probably bear a part in the production of alopecia areata. Alcohol intemperately used intensifies the symptoms of psoriasis, and favours its degenerating into exfoliative dermatitis. Dermatitis herpetiformis is possibly dominated, perhaps evoked, by diet. In some instances of lichen planus there is distinct evidence of malnutrition. Boils are often traceable to sudden changes in diet, either as to the quality or the arrangement of meals. Acne in girls is favoured by a too sparing diet. In lupus and allied tubercular affections the too limited employment of oily materials in the food of the young has a predisposing effect, a maintaining one on existing disease. The increase in the prevalence in some forms of cancerous diseases during the last half century is admitted. Two considerable alterations in dietary have occurred in the same time, an increase in the consumption of butcher's meat and of tea. But the abuse of tea is probably much more efficient in the direction of augmenting the cases of cancer than larger amounts of animal food.

On the second part, the direction of the treatment as regards diet, it is really that which is called for by the exigencies of the case immediately under our care—personal idiosyncrasy being allowed for. Food ought to be plain and wholesome. The tendency at the present day is to concentrate nutriment, to ply the system with the most easily assimilable substances offered in the form which is held

at the same time to be the most digestible. But to enable the absorbing vessels to exercise selection, this must be diluted with a sufficiency of redundant or waste material, which by its bulk opposes resistance to the muscular contraction of the stomach and intestines, thus maintaining their peristaltic efficiency and obviating constipation. However carefully our rules may be laid down, they are apt after a time to be but perfunctorily followed; hence all directions should be as plain and simple as possible.

Dr. Walter G. Smith's paper on the same subject is printed *in extenso* on page 309.

DISCUSSION.

The PRESIDENT agreed entirely with Dr. Walter Smith that the influence of diet in the causation and in the treatment of diseases of the skin was very much over-estimated. In practice, however, largely owing to prejudices of patients, one was not always able to carry out those views. The belief in the influence of diet remained still strongly rooted, and in treating patients one had gradually to educate them to more rational ideas. He noted the sometimes evil influence of "dieting" in skin disease, and mentioned a case in which the eruption subsided only when the patient was put upon a liberal allowance of food in place of a fixed and limited diet. Although laying little stress upon the direct influence of diet on skin eruptions, he emphasized the importance of good cooking for the maintenance of health, and so indirectly of a healthy skin.

In respect to particular articles of food:—Salt, he had always taught, was in itself not injurious, but salted food was often indigestible. Alcohol:—he would draw attention to the differences between varieties of alcohol. Beer and wine were much more apt to disagree than plain diluted spirit, though one had to be careful in ordering the latter, for a small and harmless dose might be increased by the patient. Starch and sugar:—in gastro-intestinal catarrh, especially in connection with urticarial and erythematous eruptions in children, these were very likely to aggravate the eruption.

As to boils, a fuller diet was often of undoubted value when any distinct lowering of health existed, but boils could frequently be entirely cured by local antiseptics alone.

As illustrating the deleterious effects of food containing poisonous materials, he showed some plates of *pellagra* disease, due to diseased rye.

Dr. HARRISON said that any rules that could be formulated and generally agreed to with regard to diet would strengthen our hands in the management of patients. He had noticed that fruit especially was liable to produce certain eruptions, although it is a popular belief that it can do no harm. It does often disagree, although quite fresh. Gooseberries and strawberries might be especially instanced. He agreed that boils were easily got rid of by local antiseptics. Among different forms of alcohol, champagne was most likely to disagree with patients. He was of opinion that "dieting" often did harm by not being sufficiently generous.

Dr. MYRTLE (Harrogate) questioned very much whether any section had been

favoured with such interesting papers as those of Dr. Jamieson and Dr. Smith. They supplied one with remarkable food for contemplation. For his part, he had ceased "to diet" patients suffering from chronic skin diseases. The essential thing was to get these patients to take sufficient digestible food. They should not be "dieted," but should have a liberal diet. He had been struck with the effect of improved diet upon leprosy in certain parts of Norway. In one hospital, in 1854, there were 2,800 cases of leprosy, whereas last year there were only 800 cases, and this decrease in numbers corresponded with a great improvement in the quality and quantity of food.

He thought that all alcoholic stimulants were harmful unless used in moderation. Tea certainly had a poisonous effect, and the great increase in its consumption was held responsible for many neuroses and much dyspepsia. He had traced gout, in many cases, to excessive tea consumption.

Dr. THIN did not believe in the evil influence of tea-drinking upon the skin. Why were these ill effects not marked in China and Japan? Dyspepsia and shrivelled skins were not disproportionately frequent there. Stimulants he thought were recommended too frequently by physicians, and he especially deprecated the tendency to advise spirits in place of beer or light wines. He was much struck with Dr. Smith's address and felt that it deserved to be more widely circulated.

Dr. DOCKRELL made some observations on the alleged immunity of Jews from tubercle.

Dr. MCCALL ANDERSON agreed in the main with Dr. Jamieson's views. He held that diet was a most important factor in the treatment of diseases of the skin, and strongly disagreed with the principle of taking "what you like." More harm was done by over-eating than by over-drinking. Attention should be paid to the teeth and proper mastication of food.

With regard to tea, it was worth noting that China tea was much better and less coarse and more aromatic than the teas of India, and less liable to produce dyspepsia.

Dr. SAVILL made some remarks as to the proper mode of preparation of tea.

Dr. BUCHANAN maintained that if dieting could not cure, it was undoubtedly of use in relieving symptoms. Itching especially could be greatly relieved by careful dieting, namely, by confining the patient to an entirely vegetarian diet.

Dr. STOPFORD TAYLOR laid stress upon the importance of rest in bed in many forms of skin disease, and spoke of the great improvement in the condition of infirm patients, suffering from chronic skin disease, after a few weeks' confinement to bed. In his opinion diet had no influence upon such cases.

Dr. ALLAN JAMIESON and Dr. WALTER SMITH replied briefly.

Mr. WILLIAM ANDERSON read a paper on a case of *Adenoma Sebaceum*, which appears in full on page 316.

The PRESIDENT said he could confirm Mr. Anderson's statements from his own experience. In one of his cases he had excised the projecting portion of the cheek just above the naso-labial groove, and having obtained primary union the linear cicatrix in the fold was scarcely noticeable, while the flattening of the cheek improved the appearance. The rest of the cheeks were vigorously scraped with a curette, but owing to the resistance of the affected skin it was impossible to

remove all the growths by this method, but some improvement was effected. Where there were only a small number of lesions electrolysis applied to each papule was the most successful method of treatment.

Dr. WALDO asked whether potassium bromide had ever been administered to the patient.

Dr. STOPFORD TAYLOR recalled the fact that mental defects were usually present in these cases.

Dr. BROOKE said that he had met with two cases of so-called adenoma sebaceum. One was an idiot girl, the other an epileptic young woman of quite average intelligence. The latter had a nævus on the lower part of the back, as mentioned by Dr. Crocker, and one on the side of the nose. He objected to Balzer's name adenoma-sebaceum, for this affection was not a simple adenoma of the sebaceous glands, and that name had long since been appropriated for such tumours as were of a purely hyperplastic adenomatous character. He had met with two such cases, in which the growth clinically exactly resembled a small patch of xanthoma, but which was found microscopically to be composed entirely of a dense mass of small lobules of apparently normal sebaceous gland. In the epileptic he had removed the growths successfully by means of a fine galvanocautery point.

Dr. ANDERSON, in reply, said that the patient had never undergone previous treatment by bromide of potassium. There were no mental defects in his case—a fact which he recognized as unusual.

Mr. GILBERT SMITH (Birmingham) read a paper on an example of *Lichen Planus Verrucosus*.

Harriett G——, aged 40, was admitted to the Skin and Lock Hospital, Birmingham, on February 4th, 1895, with a severe eruption on both legs and a slight eruption on both wrists.

Her health had been bad since the birth of her last child, fourteen years ago. She has had five children, three of them cross births; and all of her labours were hard, one child being born dead; she also had one miscarriage. She had constant pain in the region of the left ovary and severe pain in the back, both of which were relieved after an operation on the womb, which was torn during the birth of the last child. Every other day for eight months before admission she had suffered from severe frontal and occipital headaches, accompanied by vomiting. Every night there were severe cramps and twitchings of the muscles of the legs. The veins of both legs were varicose, the right one very badly.

Eight months ago the eruption began as a small pimple, hard, like a corn, about the size of a pin's head, on the outer side of the right ankle. Other pimples rapidly appeared in the same region, forming a patch, the present size of which is three inches in diameter. Over

the front of the same leg other patches formed in the same way, and a considerable number of hard "pimples" formed between these patches, and some extended up the thighs. Three months later the left leg became affected, but to a much less extent, both as to the number of patches and hard pimples between them.

On admission the patient was noted to be of about middle height, and fairly well-nourished. She had a worn expression of countenance, and a greyish-coloured skin.

The eruption was confined to the legs and arms. Over the front and sides of both legs were a number of dark-brown patches raised somewhat abruptly, their centres being much darker than their periphery. The patches varied in size from a pea to about two inches in diameter. The centres of these patches examined with a strong lens had the appearance of a group of closely-packed horny plugs. Between these patches, and extending more or less over the whole of both legs, and for some distance up the thighs, were inflamed hair-follicles, raised and tipped with hard, horny plugs. The eruption on the under surfaces of both arms was slight, and composed of the typical angular papules of *Lichen planus*. The neuralgic pain and irritation in both legs were very severe, especially at night. The cramp was also very severe, and the sick headaches with vomiting occurred daily.

This case is interesting, first as showing the probable cause as nervous exhaustion in a nervous temperament through derangement of the generative system. Secondly, partly from the extent, but more from the warty patches being derived from the conical papules seated at the hair-follicles and not from flat papules. That the process is the same as *Lichen planus* is shown by the presence of a few typical papules on the extensor surfaces of the forearms, and a few pitted ones on the flexor side of the left wrist.

The PRESIDENT observed that, in cases of *Lichen planus verrucosus*, the warty patches were connected with the follicular papules and built up of these. They did not arise from the flat papules originating in relation with the sweat-ducts. He contrasted and compared these conditions with those he had already referred to as existing in *Pityriasis rubra pilaris*.

Dr. NORMAN WALKER objected to the term "*verrucosus*." The condition in *Lichen planus verrucosus* was not really that of a wart, but was merely an overgrowth of epithelium without increase of connective tissue.

Dr. LESLIE ROBERTS read a paper on the *Treatment of Trichophytosis Follicularis (Ringworm) based on the Physiology of the Trichophytons*. Dr. Roberts said that hair, considered scientifically, was the formed secretion of the cutaneous follicle. Chemically it was as remote from the living substance of the body as it was possible to be. It was unaffected by the soluble ferments, whether acting in an acid or alkaline medium. It was proof against the agents of putrefaction. In the mineral kingdom it was disintegrated and partially dissolved by certain substances whose action was considered by physiologists as analogous to the action of soluble ferments, namely, by strong acids and alkalies. There existed in the vegetable world a class of minute flowerless plants containing a ferment, by whose agency hair could be more completely dissolved than by the strongest acids or alkalies. These minute plants were the *keratolytic fungi*.* Chemically speaking, ringworm consisted in the disintegration of the complex carbon-nitrogen compound, keratin, into simple carbon compounds and nitrogen compounds which were assimilated by the fungus. It followed from these facts that when once the fungus had entered into the interior of the follicle, it was master of the situation, since it possessed a power which we did not, of digesting keratogenous tissues without employing the use of caustic agents. We were, therefore, at a complete disadvantage in our efforts to control the fungus. The lesson which we had to learn was, that when once the fungus had entered into the interior of the follicle, we ceased to have any further *direct* control over it.

The ways and means at our disposal for controlling the operations of the fungus were next discussed. We have it completely in our power to prevent the development of fresh foci, and the scattering of the fungus from one part to another, since the fungus always travels from one follicle to another by the external surface. But when once the fungus has entered into the interior of the follicle, we can influence its life only in an indirect way. This indirect therapeutic influence consists in our power to artificially provoke proliferation of the living cells of the follicle, and to excite the subjacent blood-vessels. After referring to some practical points in the anatomy of the hair-follicle, Dr. Leslie Roberts entered upon the relationship of the fungus to the living

* The experimental proofs are given by Dr. Leslie Roberts in the *Journal of Pathology and Bacteriology*, Vol. III., July, 1895.

hair-forming cells. He said its action was to inhibit the normal proliferation of these cells, and sometimes this inhibition was absolute for a time, as in "tinea decalvans." It was just on these cells that our therapeutic influence could be brought to bear by means of irritants deposited upon the surface of the skin over the affected follicles. Under normal excitement physiological proliferation resulted, of course, in the formation of hair, and the thin insoluble membrane (inner root-sheath) lining the interior of the follicle. If the excitement went beyond physiological bounds, proliferation became luxuriant, and pus was the result. The formation of pus, commonly a useless product, was of great service in the morbid condition of the follicle which they were then considering. The practical difficulty was how to control the suppuration. Pus, which resulted from the proliferation of epithelium, was produced without any considerable loss of substance, and without ulceration (Virchow). But loss of substance and ulceration were invariably the case when pus was produced in connective tissue. Regarded in this light, the problem of how to treat trichophytosis follicularis could be enunciated as follows:—To excite the soft cells of the affected follicles to a physiological proliferation, or to a luxuriant (pus formation) which should not pass beyond the limits of the epithelium. The remaining portion of the paper enlarged upon this theme, and concluded with a summary of the present state of our knowledge of the pathology and therapeutics of trichophytosis follicularis.

Dr. EDWARD MACKEY (Brighton) read a paper on *Cheiro-Pompholyx in association with Eczema*. After referring to Tilbury Fox's description and plate of Dysidrosis ("erroneously termed Cheiro-Pompholyx") and his statements that it was "not inflammatory," and that "nothing could be more different than the origin of this and eczema," the paper offered reasons for re-considering this position, and related cases in which the two disorders were so closely associated as to raise a presumption that they were practically the same. The importance of recognizing this bore especially on *prognosis*, for instead of having to deal with "a vesicular and bullous eruption limited to hands and feet, and of two to three weeks' duration" (Crocker), such a condition might spread over the whole body with the more common characters of general eczema, and a duration of months. This was

so in the first case narrated—that of a neurotic depressed lady of about thirty-seven. The second case, also in a woman of middle age, and over-worked, presented large bullæ in the palms of both hands—like those seen on the fingers in Mr. Hutchinson's case, but at the same time there was seborrhœic eczema of the head, and later, catarrhal eczema of the arms.

Whilst Tilbury Fox positively, and Crocker to a less extent, connected Pompholyx (Dysidrosis) with obstruction of sweat-glands, the latter authority recognized also some inflammation of the papillary layer, and a "close resemblance to vesicular eczema palmarum"; other observers—notably Robinson and W. Williams—failed to observe any implication of sweat-glands, and inspection of the sections of Williams made from his own hands, shows certain evidence of inflammation of papillary layer, with exudation of serum, which is practically the pathology of eczema. Further, Dr. Jamieson speaks of the "easy transition to true eczema," and describes Dr. Fox's typical plate as a "not uncommon type of eczema in neurotic persons," and relates a mixed case very similar to the first in this paper. It is concluded that although some of the appearances—such as "sago grains" and more rapid drying—may seem different for a time from ordinary eczema, yet the condition (termed now simply Pompholyx rather than Cheiro-pompholyx) is in reality a variety of that disorder, and cannot rightly be called a Dysidrosis.

The PRESIDENT agreed that these cases frequently resembled eczema, and would call them sweat-eczemas. There were, however, certain cases in which the lesions consisted chiefly of bullæ, and were limited to the hands without any eczematous condition being present, and to which the term eczema could not be applied.

Dr. BARENDT's paper on the same subject is published in full on page 818.

Dr. HENRY WALDO (Bristol) then read a paper on *Alopecia Areata*. He said:—My chief object in reading this paper is to elicit the opinion of other dermatologists regarding the ætiology of the patchy form of Alopecia areata. I do not wish to deal with the rapidly universal cases, as I believe they are generally admitted to depend upon a tropho-neurotic origin. From a pathological point of view, no one micro-organism has been demonstrated to be present in all, or even

in most, cases of patchy alopecia. Atrophy of the follicle and its contents appears to be the most constant condition. And, clinically speaking, the large majority of cases of the patchy form of alopecia areata do not appear to me to depend upon a fungus. The cause is often, I think, over-work with too little sleep, and unsatisfactory hygienic conditions, and perhaps, in addition, malnutrition. No doubt worry, nervous shock, or anxiety play a part in some of these cases. The best results were obtained in my cases by improving the patient's general condition and giving cod-liver oil, and often arsenic—two remedies which are so useful in other neuroses. I believe that change of scene and leading an out-door country life for a prolonged period is almost more beneficial than anything else; but this is difficult to obtain for hospital patients, and the disease occurs most frequently among the poor. These cases often get well without the application of parasitocides, and this fact strengthens the neurotic theory. I consider moderate stimulation of the more or less anæsthetic surfaces an advantage, and the external application I mostly prescribe is the linimentum camphoræ compositum rubbed into and around the patches. I direct that any loose hairs are to be pulled out. Dr. Payne has recently called attention to the good effect of sulphur and bichloride of mercury applications in promoting the growth of hair, and, I imagine, quite irrespective of their anti-parasitic action. I have used these drugs in a large number of cases, often combining them with beef-marrow with most satisfactory results. I have not yet given oxygen gas a trial. Thyroid extract internally has proved a failure in my cases.

MR. GEORGE PERNET read a paper on *The Ætiology of acute Pemphigus*. Referring to a fatal case of acute Pemphigus* which had recently come under his observation, he stated that he had been able to collect four other very similar cases, all like his own, occurring in young journeymen butchers. In three, the disease was fatal in from ten to twenty-eight days. In two cases, one of which recovered, there was a distinct history of a wound, inflicted whilst dressing sheep's heads. He also alluded to two other cases. Adding the whole of the cases together (seven), including his own, no less

* *The British Journal of Dermatology*, April, 1895.

than six terminated fatally, and in three there was a distinct history of an injury to the hands.

In a second series of eight cases he had collected, apart from butchers, but where the nature of the occupation brought the patient in contact with animals or dead portions of animals, the acute bullous eruption was fatal in five (four females, one male). In three of these eight cases there was a distinct history of injury to the hands, and in two others a whitlow of the finger was noticed on admission to hospital.

The case of a man who attended horses and milked cows was specially interesting from the fact that the disease followed a wound of the hand and was contracted by inoculation from the teats of a cow. Mr. Pernet then touched upon bullous eruptions found in horses, cattle, &c.

With regard to the bacteriology of the case which he had observed, a diplococcus had been found by Dr. W. Bulloch,* which agreed with the organism first described by Demme, and more recently by Claessen.

Mr. Pernet arrived at the following conclusions: (1) There is a group of rare cases of acute bullous eruption, accompanied by severe constitutional symptoms, and generally terminating fatally, which affects butchers; (2) The disease follows a wound of the hands or fingers, and (3) is probably due to a micro-organism. (4) The same ætiological factors are probably at work in another group of very similar cases, and affects those who handle animals or dead portions of animals, such as hides, meat, &c.

He suggested that in future the following points should be looked for in cases coming under observation: (1) Occupation (butcher, &c.); (2) History of a wound; (3) Presence, or absence, of a characteristic micro-organism, *i.e.*, Demme's diplococcus; (4) Contact with animals.

In conclusion, Mr. Pernet insisted on the importance of thoroughly disinfecting, with powerful antiseptics, all wounds of the fingers and whitlows occurring in butchers and those handling meat, &c.

The author further stated that he was preparing a general survey of the literature of Pemphigus for a future paper.

* *The British Journal of Dermatology*, May, 1895.

Friday, August 2nd.

Clinical Demonstrations.

Dr. RADCLIFFE-CROCKER exhibited (1) a case of diffuse *Psoriasis*, which had been benefitted by treatment with salicylate of soda.

(2) A typical example of *Xeroderma Pigmentosum* in a woman, aged 21 years. A brother and sister of the patient were similarly affected.

(3) A boy, aged 9 years, the subject of *Urticaria Pigmentosa*. The eruption was typical, and factitious urticaria was well marked. The disease had begun at an unusually late age, viz., 6 years.

(4) Two cases of *Morphæa*, of fifth-nerve distribution.

(5) A case of *General Sclerodermia* in a diver. The condition had existed for three years, and was now improving under massage and Turkish baths.

(6) *Alopecia Areata*, in a boy, of five years' duration. Treatment by oxygen gas had been employed for three months without obvious benefit.

Mr. GEORGE STOKER also showed a case of *Alopecia Areata* which had been under oxygen gas treatment for two months. An abundant growth of long white hair had taken place, and Mr. Stoker attributed Dr. Crocker's want of success to the use of a badly fitting cap.

Dr. ABRAHAM COHEN showed a case for *Diagnosis*. There were large dark brown papular growths over the front of each leg. Dr. Cohen regarded the case as one of Multiple Sarcomatous Dermatoses.

Dr. PYE-SMITH exhibited two cases :—

(1) *Acanthosis Nigricans*. The disease was of five or six years' duration only. The patient was an elderly man. There was a general deep bronze colour of the skin, especially over the trunk. On either side of the neck and abdomen there were patches of characteristic pigmented papillomata.

(2) *Multiple Cysticerci* in a young and healthy soldier who had served in India. There were thirty or forty small round or oval tumours scattered over the body, and situated immediately below the skin. One of these, removed for examination, showed the characteristic hooklets, etc.

Mr. MALCOLM MORRIS brought forward (1) a case of *Symmetrical Sclerodermia* in an elderly woman. The sclerodermia was in parts associated with painful ulcers.

(2) A boy with a very superficial form of *Tuberculosis cutis*: or "*Lupus vulgaris erythematoides*" of Leloir.

(3) Two examples of *Leprosy* in patients who had resided in India.

Dr. COLCOTT FOX presented (1) a good example of *Mycosis Fungoides*. The skin exhibited the general eczematous condition, and there were numerous tumours in various stages of evolution and involution. Several were very extensive, ulcerating and sloughing. The disease was of about ten years' duration.

(2) A large *Rodent ulcer* in a woman, aged 57, in an unusual situation, viz., over the upper part of the sternum.

(3) A boy who was the subject of a *Relapsing Erythema*, occurring always in the summer, and allied on the one hand to chronic urticaria, and on the other to *Hydroa vacciniforme vel æstivale*.

Dr. GALLOWAY showed a case of *Idiopathic Multiple Pigmented Sarcoma* in a

Polish Jew. The lesions were now subsiding, though at one time the disease was so extensive in one leg that the limb was amputated.

Dr. MORGAN DOCKRELL presented two cases :—

(1) A case of *Ichthyosis Hystrix*, in a girl aged 15, in whom the disease was confined to the face and scalp.

(2) *Adenoma Sebaceum* in an epileptic boy. The disease had existed since birth, and was confined to the face. There were cicatrices which seemed to point to the spontaneous involution of some of the growths.

Dr. ALFRED EDDOWES exhibited a case of *Eczema palmare* to demonstrate the good result of treatment by salicylic acid ointment. He also showed another case of *Eczema* and one of *Angiokeratosis* on the leg of an elderly woman.

Mr. JAMES STARTIN demonstrated a case of *Superficial Rodent Ulcer* of the forehead, and a case of *Congenital Xeroderma*.





West, Newman chromo lith.

Dr Colecott Fox's
case of ACNE SCROFULOSORUM in an infant

THE BRITISH JOURNAL OF DERMATOLOGY.

NOVEMBER, 1895.

ON ACNE SCROFULOSORUM IN INFANTS.*

BY T. COLCOTT FOX, M.B. LOND., F.R.C.P.,

Physician for Diseases of the Skin to the Westminster Hospital, and to the Skin Department of the Paddington Green Children's Hospital: late Physician to the Victoria Hospital for Children.

I DESIRE to bring to your notice a somewhat uncommon papulopustular or acneiform eruption I have met with in infants. My attention was attracted to it more than fifteen years ago, and I have from time to time observed examples in the intervening years, but not more than about ten cases. I shall not weary you by reciting the detached notes of all these examples, but will pick out one or two in order to illustrate the difficulty which I have experienced in coming to a conclusion as to the nature of the affection. Moreover, there is a remarkable similarity in them all, and when once an example has been studied there is little difficulty in recognizing the eruption thereafter.

CAROLINE F., aged 7½ months, came under my care at the Bell Street Dispensary on February 17, 1883. The mother had never suffered from any eruptions. Of her eight children, six were living, the first having died of bronchitis at 2 years and 3 months of age. The seventh child was said to have had an eruption similar to that of Caroline, and she died, aged 5 months, of bronchitis and croup. There was a miscarriage between the sixth and seventh child. The father was reported healthy. Caroline was the eighth child. She had "thrush go through her" at 6 to 8 weeks of age, and when

* Read to the Section for Dermatology at the Meeting of the British Medical Association, July-August, 1895.

I saw her had snuffles, some conjunctivitis, and rather a harsh voice. She was fairly well-nourished. Vaccination performed at four months took well, and was followed by an eruption which appeared about one week after. When I saw the child the eruption, depicted by the late Mr. Hurst in the drawing I pass round, had existed probably about two months. It was said to have appeared first over the arms and hands, then on the legs, and then on the thighs and gluteal region, and to have come out in successive crops. Old ones died away and new ones appeared. When I saw her the eruption was disseminated over the buttocks to the small of the back, and over the thighs and legs, mostly on their extensor aspect, and also over the extensor surface of the forearms. There were a few on the flexor aspect, and one or two just above the elbow.

The eruption consisted of indolent, isolated, dull-red, shining, flattish papules, in size from a large pin's-head to a small split-pea. Many had a yellowish-white appearance about the summit, as if about to pustulate. The whitish colour was apparently due to the distention of the mouth of a follicle with débris. The appearance closely simulated that of a drying varioloid or pustular syphilide. With a magnifying glass the papules were seen to be primarily conical, and in the process of involution to flatten down. When the follicular plug fell out, as sometimes happened, a curious crater-like appearance resulted. There was but little itching. The child was rather gross and flabby, and looking back on the case I suspect she had adenoids. There were, however, no glandular enlargements nor scrofulo-tuberculous gummata.

ISABELLA H., aged 9 months, was sent to me by my colleague, Dr. Leslie Ogilvie, and I made the following notes in 1885 :—

She is the fourth child. The first died in the hospital of tuberculous meningitis, aged 20 months. The second and third are living and healthy. Isabella and the second and third "had thrush go through and come out on the bottom." She has had chronic snuffles since four months old. Physiognomy fairly good, except perhaps the bridge of nose rather sunken; no cranial bone changes; spleen not enlarged; complexion anæmic and transparent; no head sweats or rickety changes, but won't keep bed-clothes on and can't sit up properly. Geographical rings on the tongue. Mother's father died of consumption.

months after the cessation of bromides; (2) That the eruption should be limited to the face; and (3) That it should be so unlike the ordinary bromide outbreak.

Mr. MALCOLM MORRIS showed a case of *Favus* of seven years' duration in a boy aged 12, of English birth, who had always enjoyed good health and had never been in contact, as far as could be ascertained, with any one suffering from a similar condition. When first seen, on June 13th, 1895, there was a mass of crusts and sebum swarming with pediculi, measuring about two inches in diameter, over the right parietal region. In August, after treatment, cicatricial atrophy and hairs containing favus fungus could be discovered, although there were no favus cups. Characteristic cultivations of the achorion had been obtained.

Dr. J. J. PRINGLE showed (1) a woman, aged 70, who had suffered from *Lichen planus* for twelve months. On the right leg, which was the part first affected, there were two large, very hypertrophied, warty-looking purplish plaques, with no outlying papules; the veins were not varicose. The left leg was unaffected. Over both forearms and backs of the hands were fairly numerous, characteristic papules and a few composite patches. In front of the left ear was a raised, papulo-squamous plaque the size of a sixpence of doubtful nature; the mucous membranes were unaffected. All the lesions were extremely itchy.

(2) and (3) Two cases of *ulcerating hypertrophic Lichen planus*. The former was in a man, aged 44, who had been exhibited to the Society in 1891 for a condition similar to the present, which had never subsided. The lesions, which were very typical, conglomerate, raised plaques of deep purplish-brown colour, were confined to the lower three-fourths of the outer surface of the right leg. The occurrence of ulceration in the centre of the largest patch had induced him to seek advice again after an absence of nearly four years from the Hospital, the ulcer being circular, the size of a sixpence, and superficial. As the part had admittedly been scratched, there was considerable probability that the ulceration was due to this cause and to the inoculation of pus cocci; and this view was supported by the fact that it healed up rapidly under ammoniated mercury ointment and a protective dressing.

Case (8) occurred in a stout man, weighing sixteen stone, and 55 years of age, who had been a free drinker. He came under observation in the beginning of June, 1895, when his disease was of three years' continuous duration. On both legs, but most marked on the right, were characteristic patches and sheets of very hypertrophic lichen planus, sharply demarcated, their surface thickly honey-combed with minute pits—the dilated orifices of pilo-sebaceous ducts. The veins were markedly varicose. In the centre of the infiltrated areas were several ulcers, of indolent appearance, with unhealthy-looking slough on their bases, the largest of which measured half an inch vertically by one inch transversely. And as the lesions were not itchy, and the parts had been covered with a protective dressing, there was good reason for believing that the ulceration was independent of traumatism, although probably dependent mainly on the varix present.

Another point of interest in the case was the pronounced tendency in the patient to warty formation; numerous rows and groups of papules on the extensor aspect of both forearms, absolutely characteristic of lichen planus when the patient first came under observation, having by the date of exhibition become macroscopically indistinguishable from ordinary flat warts, of which he had a large crop on the forehead.

Although the swelling and general appearance of the legs had improved under treatment by firm bandages, etc., the ulceration had proved most rebellious, and several fresh ulcers had formed.

Dr. PRINGLE also showed (4) a case of *Tricophytic conglomerative Perifolliculitis* of the wrist, of six weeks' duration, in an ostler, who had been working with a horse suffering from several patches of ringworm one month previous to his noticing the disease. The condition had probably been aggravated by poultices applied by a medical man ignorant of the nature of the disease. In two hairs only (owing to the advanced suppuration) was fungus found, which corresponded to the description of Sabouraud of the "*Tricophyton ectothrix pyogène du cheval*," except that the mycelium was present inside as well as outside the hair, as in the case referred to by Dr. Adamson at page 242 of the Journal for this year. Characteristic snow white, rayed cultures on Sabouraud's "*Milieu d'épreuve*" from the latter case were exhibited.

The eruption has been out about three months, and has not varied in appearance. There are—

(1) Little miliary conoidal papules, mostly in obvious relation to follicles, which have a central plug of débris. The papules are the size of small acne.

(2) Similar lesions with slight central pustulation, leaving some pigmentation and very faint scars, if any.

(3) Crateriform lesions forming by the occasional shelling out of the central plug.

(4) Papules of similar size somewhat flattened down, and without any obvious central plug.

(5) Still more flattened papules with shining surface and somewhat irregular border, strongly reminding one of lichen planus.

The older lesions are more violaceous than the younger. They are all very indolent. The eruption is disseminated somewhat sparsely over the extensor aspects of the arms, forearms, thighs and legs, the sides of the face, the scalp to a very slight extent, but thickly over the buttocks and small of the back. I was informed that the lesions came first at the bottom of the back, then on the arms, and finally on the legs.

This child continued under my care for some time, and I noted that all the lesions were developed round a follicle, that they appeared as more or less obtusely conical inflammatory papules, and acquired almost invariably some degree of apical pustulation, which was not enough to form a crust. The papulo-pustule dried up, the central plug fell out, leaving a crater, and then the lesion flattened down, became more violaceous, and left a faint stain, or scar, or pit. I witnessed subsequently a subacute outburst of the eruption.

In my Report of the Department for Diseases of the Skin at the Westminster Hospital for 1886 (*Westminster Hospital Reports*, vol. iii. 1888), I recorded the following case:—

HAROLD W., æt. 2, was brought with a miliary papular and acneiform eruption developed about the follicles over the whole of the legs and thighs, but mostly situated on the extensor aspects. The dull red or livid papules are miliary in size, mostly inclined to be acuminate, but some crateriform; many passing on to an acneiform stage, and often leaving little scars. As they decline, many papules flatten down and look remarkably like lichen planus, but

have not the same abrupt angular contour. In this otherwise well-marked case there are two variations from the usual condition—firstly, there is no eruption on the arms; and secondly, there are a number of indolent circumscribed violaceous phlegmons, the size of half a walnut, on the legs, also one on each arm. There is no history of syphilis, nor anything of moment to be ascertained about the family.

I remarked that “it is no doubt difficult to realize this eruption from a description alone, but the affection is a well-marked one, rather rare, always presenting similar features, distributed in moderate profusion on the limbs, mostly on the extensor aspects, indolent and chronic, and occurring in the first two or three years of life. I have naturally closely examined into its syphilitic causation, but I am very doubtful about it. It dies away in a few weeks or months under general tonic treatment, by cod-liver oil, &c., but whether spontaneously or owing to the remedies I cannot say.”

On March 8rd, 1888, ARTHUR L., aged one year and seven months, was brought to me at the Paddington Green Children's Hospital. There were four children in this family all alive. No mishaps or still-births. Arthur had suffered from abscesses since ten months of age. They formed in the groin, on the flexor aspect of the right wrist, above the back of the left elbow, and on the head. There was a geographical tongue, and the spleen was palpable below the umbilical level. The mother thought the child “had the thrush go through him,” but was rather hazy on this point.

When I saw the child there were marks of an old sore at the corner of the mouth and the peculiar follicular eruption. There were a few lesions about the left elbow, slightly pustular or crateriform. They were thickly disseminated over the backs of the feet, and over the legs below the knee. Here they were rounded, flattened, in size from a pin's-head to a quarter of a pea, violaceous, follicular, with a central crater or opening. They were especially copious up the backs of the legs. On April 22nd, 1888, the child had severe double otitis. There was no cranial bossing or rickets of the bones, but the spleen still extended half way down to the umbilical level.

I will also bring to your notice the case of ARTHUR P., aged one year and eight months, who was brought to me at the Westminster Hospital on November 28th, 1888. There was the character-

istic papulo-pustular eruption seated about the follicles of the extensor aspects of the upper and lower extremities. The upper extremities were the least involved. The conical shape of the early papules could be traced, and to some extent the flattening down in the involution stage. The papulo-pustular or acneiform character was well-marked, and its follicular localization. There was nothing in the family or personal history of this child which threw any light on the nature of the affection.

Lastly I will mention the case of a baby seen in my private practice, which I believe should be placed with the other cases. The boy was said to be a splendid baby at birth, but at three months of age he became languid, restless, out of sorts, and developed snuffles. At five months old the eruption under consideration developed. When the child was brought to me at eight months of age he was pallid and had a flattened bridge to his nose. The body and limbs were dotted over sparsely with a miliary papular eruption, closely simulating lichen planus, smooth, shining, pale red or pink, flattened, rising abruptly from the skin, not umbilicate, rounded in outline, or more or less angular. One or two papules were acuminate, and a few crateriform and evidently follicular. There were a few on the face. The large flexures were free. There was nothing to be gleaned from the family history. One year later, when I saw the child, the eruption had disappeared, but a dactylitis had developed.

I regret that I have not made any histological or bacteriological observations.

REMARKS.

The eruption is, then, an indolent, small papulo-pustular or acneiform one met with in infants, disseminated for the most part sparsely, and without grouping, and unaccompanied by any marked subjective symptoms. It affects the limbs particularly, and especially their external aspects, the lower extremities mostly, and notably the buttocks and the regions immediately above. The lesions appear successively or by a subacute outbreak. The papules are inflammatory, seated about a hair-follicle, and acuminate in the early stage. They mostly develop a slight crown of pus, which dries up and often shells out with a central follicular plug, leaving a crater. The papules in involution become flattened and more irregular in outline, simulating lichen planus, and they tend to leave stains or faint scars.

What is the nature of this affection? My first impression was in favour of its syphilitic nature, and I used to treat the children with mercury, but without any benefit. I do not, however, believe that the affection is syphilitic, because the syphilitic history in these cases is always very problematical, the eruption does not respond to anti-syphilitic remedies, and because I have never seen it arise in the course of any undoubted case of hereditary syphilis, notwithstanding that an acneiform eruption is well known in acquired syphilis. I then fell back on the vague "scrofulous" theory, and now generally administer cod-liver oil and iron. During this treatment the eruption usually disappears. The subjects of this affection are not typically healthy; they are often gross in habit, flabby, with chronic catarrh of mucous membranes, and have a history of "thrush going through," and so on. In my experience it is the exception to find any strong family history of tuberculosis or any personal history of marked scrofulo-tuberculous lesions, like gummata or bone disease. However, in two of the cases to-day recited scrofulo-tuberculous gummata were present, and in a third strumous dactylitis. I now look on the eruption as one not due directly to tuberculosis, but as occurring in certain infants with poor nutrition, who are prone to tuberculous infection, which may have already occurred. In such children it is very likely that a pyogenic organism finds a favourable soil in the follicles.

I am inclined to include this affection with one met with in older children and adults, which I have long known under the term *Acne scrofulosorum*. We have had several good examples exhibited in late years at the Dermatological Society of London. One cannot fail to be impressed with the close similarity of the eruption itself, its distribution on the extensor aspect of the limbs, and its occurrence in subjects who may be called "scrofulous," or who suffer from evident tuberculous lesions.

Dr. Radcliffe-Crocker described three such cases in children aged 3, 5, and 10 years respectively, to the International Dermatological Congress, held in Vienna in 1892. I think Bazin was the first to note the affection in his "Leçons sur la Scrofule," under the term *Acné scrofuleuse*.

He recorded a case of a boy of 17 years who had enlarged and suppurating submaxillary glands in childhood. The whole body was

covered with little red pustules, acuminate, from the head of a pin to a millet-grain in size, disseminated and discrete, or confluent, in little groups. He said it was very rare, that its seat was the sebaceous system, that it was unaccompanied by itching, and that it did not leave cicatrices or pigment stains.

In searching for other records I have been very unsuccessful, though the eruption must be known. I cannot, however, find any description under the term *Acne scrofulosorum*, and I cannot trace any reference under *Lichen scrofulosorum*, *Acne cachecticorum*, *Scrofulides*, &c. It is possible, however, that Kaposi includes it in the following description ("Pathologie et Traitement des Maladies de la Peau," second French edition (Besnier and Doyon, vol. I., 1891, p. 742) :—" *Acne cachecticorum* (Hebra) shows itself in individuals considerably enfeebled, marasmic, or in scrofulous subjects, and, consequently, often associated with lichen scrofulosorum; scanty on the face, it occupies especially the trunk and lower extremities. It consists in the production of papules and pustules of the volume of a pin-head to that of a lentil, flat, soft, of a livid red, which closely resemble syphilitic efflorescences. But they are distinguished chiefly by the absence of the hard infiltration which characterizes syphilides, and by the fact that they never give rise to specific ulcerations, but at the most to superficial and flabby projections of tissues infiltrated by hæmorrhage." In Bulkley's "Treatise on Acne" I cannot trace any description of *Acne scrofulosorum*, but in the extensive Bibliography appended I find a reference to a case recorded by Aubert in the "Annales de Derm. et de Syph.," Paris, first series, vol. X., 1879-80, entitled *Acne indurée généralisée sur un enfant*, &c. I have been unable to refer to Waldenström in the "Upsala Läkare Förh.," 1877-8, on *Phlegmone et acne granulosa S. scrofulosorum*. Lastly, Dühring ("Practical Treatise on Diseases of the Skin") gives a description of a small pustular scrofuloderm, which does not quite tally with the cases of which I have experience.

The differential diagnosis of the eruption to which I call attention is not difficult, except as regards the acneiform syphilide. It is easily distinguished from the various small pustular eruptions of a more acute character, and of acneiform or sycosiform aspect, such, for instance, as the *Urticaria pustulosa* of children (Varitella - and *Vaccinia-prurigo* of Hutchinson).

Its indolence and distribution will so serve to prevent any confusion between it and *Urticaria papulosa* in the absence of wheals, though in both the declining papules may simulate those of *Lichen planus*.

I have never met with a similar acneiform eruption in hereditary syphilis, but in adults, especially if bearing scrofulo-tuberculous lesions, the diagnosis is often one of much nicety.

Note.—I was interested to observe in the Museum a portrait executed some years ago by direction of Mr. Marrant Baker, and now in the collection of St. Bartholomew's Hospital, entitled "A Peculiar Form of Lichen in a Child." The eruption was evidently *Acne scrofulosorum*.

DISCUSSION.

Dr. ALLAN JAMIESON had seen several of these cases, and had published two cases in the *British Journal of Dermatology*,* under the title *Impetigo varioliformis*. In these two patients the crateriform appearance of the lesions was well marked, and there were scars remaining after healing. He had noticed that the eruption was distinctly infective, a fact which favoured the parasitic view of origin. He referred to a plate in the Sydenham Society's "Atlas,"† entitled, "*Molluscum Contagiosum*," but evidently an example of the disease described by Dr. Fox.

The PRESIDENT was much interested in this paper. He had recognized the affection for some time, and had called attention to it at the meeting of the Dermatological Congress in Vienna.‡ He had also termed it *Acne scrofulosorum*. He agreed with Dr. Fox that the subjects of the eruption were strumous children. He had met with no evidence of contagiousness. With regard to distribution he would emphasize the fact that the buttocks and thighs were generally the seat of most copious eruption. The disease was rare, and was met with seldom at skin clinics, but more frequently at Children's Hospitals.

Dr. WALLACE BEATTY (Dublin) also remarked that the disease was very rare. He had recently seen a case in Dublin, which exactly tallied with Dr. Fox's description. Here, among other evidences of scrofula, there were corneal ulcers. A peculiarity of the case was that the scars of former lesions took on a keloid growth.

Dr. DOCKERELL thought it a pity to extend the term "*Acne*" to this condition. It undoubtedly occurred in tubercular people, and it would be more correct to call it a papular affection of tubercular origin.

* *British Journal of Dermatology*, Vol. VI., 1894, p. 294.

† "Sydenham Society Atlas," Plate XLVI.

‡ Transactions of the Second International Dermatological Congress, Vienna, 1892, p. 510.

THE TREATMENT OF SYPHILIS BY INJECTIONS OF SYPHILITIC ANTITOXINE.*

BY EDWARD COTTERELL, F.R.C.S.,

Surgeon to Out-Patients at the Lock Hospital, &c.

In the treatment of syphilis a very large number of drugs have at various times been lauded as specifics. At the present time there is a tendency to treat contagious diseases with serum derived from an immune animal, and his object was to give the results he had acquired by treating syphilis with injections of serum obtained from an individual who had had syphilis.

Syphilis has been, and is now, being treated by some surgeons with injections of animal serum, the rationale of this treatment being that as no one has yet succeeded in producing any of the manifestations of syphilis by inoculation or otherwise in the lower animals, there must be some property in their tissues which renders them immune to syphilis.

Dr. Frederick Mott had suggested that possibly the injection of serum obtained from a person who had gone through an attack of syphilis, and so had been rendered immune to subsequent attacks, might be more efficacious in the treatment of a recent attack of this disease than the serum obtained from animals, and the speaker had determined to put this method of treatment into practice.

The following arguments had led him to this experiment:—

(1.) One attack of syphilis confers immunity from subsequent infection upon the individual affected, the exceptions to this rule being so rare that they may be entirely disregarded. Therefore an individual who has, or who has had syphilis possesses some property within himself which renders him immune from any fresh infection from this disease.

(2.) Although at the present time it has not yet been definitely

* Abstract of a Paper contributed to the Section for Dermatology at the Meeting of the British Medical Association, July—August, 1895.

proved, still it is highly probable that syphilis is due to some specific micro-organism, and that the symptoms of so-called "secondary" syphilis are due to the production by this specific bacillus of a toxine. So again it is probable that the immunity observed from second attacks of syphilis is due to the presence of some material in the blood which for want of a better name we may term "syphilitic antitoxine."

This is consonant with Dr. Klein's statement that "When an animal has passed through one attack of a given infectious disease—that is when an animal has served as a host for the growth and multiplication of a particular pathogenic bacterium, it is found that its blood has acquired a peculiar faculty. The blood has become capable, not only of inhibiting the further growth of the bacterium, but also of neutralizing the toxins produced by the bacterium."

Animals, therefore, which have acquired immunity, possess in their blood a something that they had not before, and this substance belongs to a group of substances called "antitoxines."

(8.) It is a matter of common observation that a child, the subject of hereditary syphilis, may be born of a woman who has never exhibited—as far as can be made out—a single sign or symptom either of the primary or of the secondary manifestations of syphilis, and in addition she shows herself immune to the poison of that disease, for she cannot be inoculated with it either by her own syphilitic offspring or by the poison from any other source.

Without going too deeply into the nature of this strange immunity, he suggested that it might be perhaps explained by presuming that by some means, possibly due to some peculiar property of the placenta and its circulation, only the syphilitic antitoxines from the foetus reach the tissues of the mother, and in this way she is rendered immune to the disease which the father has transmitted to his offspring.

Passing on to the practical application of these theories, he briefly related the results so far obtained in eighteen cases where this method had been the only one employed in treating the disease.

1. In the early stages of syphilis, *i.e.*, when there is only a sore and glandular enlargement, injections of this serum cause the sore to heal rapidly. The adenitis in the groin generally becomes intensely marked, the skin and throat symptoms are absent, or only slightly marked.

2. Where the case is not seen until the rash and throat symptoms develop, the skin eruption fades rapidly, much more rapidly as a rule than under mercurial treatment, but the throat symptoms disappear rather slowly.

3. The general health improves.

4. The serum from an individual with well-marked secondary syphilis appears to be more active than that obtained from a patient with tertiary symptoms.

5. The amount to be injected has not been accurately determined, but he had used the serum in doses of half to five c.c.

These conclusions were arrived at after over six months' experience with the method of treatment. The number of cases was too small and the length of time too short to make more definite statements upon the method, but he would be glad if other members of the profession would give the method a trial and report upon it. He especially recommended its trial and report by army surgeons, as they have the best opportunities of observing the results of treatment of syphilis, from the fact that they can keep their cases under observation for a prolonged period, a thing which is next to impossible with hospital patients.

SOCIETY INTELLIGENCE.

DERMATOLOGICAL SOCIETY OF LONDON.

An ordinary meeting of the Society was held on Wednesday, October 9th, 1895, when:—

Dr. ADAMSON exhibited a case of *Urticaria pigmentosa* in a boy aged 15 months. At birth, and till the child was two weeks old, the skin was said to be "blue mottled." At that age, red raised patches appeared. They all seemed to come suddenly, and are said not to have increased in number since. During the first year of life the patches were said to be redder than now, and they used to swell up when the child was undressed or when he cried. During the last four months they have been getting browner, and have not swelled and reddened so often.

October, 1895.—The eruption is general and very copious, but only sparsely present on the hands and feet, and less abundant on the face than on the trunk. The lesions consist of small *café-au-lait* coloured patches, scattered thickly over the skin surface. Most are not raised, but over the shoulders, the lower part of abdomen, and the thighs they are slightly elevated. On pressure, the colour becomes paler, but does not disappear. There are no lesions on the mucous membranes. A pigmented patch the size of a shilling is present over the left side of back.

While in hospital the general condition of health has been good, and the lesions have never become urticarial except after continued friction.

Dr. CAVAFY showed a *peculiar affection of the hand and arm, following Zoster*.

A man, aged 78, came under observation in July, 1895, suffering from *Zoster dorso-brachialis* of the left side. The case was one of exceptional severity, characteristic clustered, somewhat flat vesicles

of large size occurring in the left interscapular region, a few over the pectoral muscles, and a large number down the inner side of the arm and forearm; in the latter position there were also clusters on its flexor and extensor aspects, especially near the wrist, and several large vesicles were found on the palmar aspect of the hand and fingers. There was much redness of the skin in the neighbourhood of the vesicles, and the hand, wrist and lower third of the forearm were much swollen; pain had been severe a day or two before the appearance of the eruption, and remained so throughout. The vesicles became purulent, and were very slow in drying up and healing, one or two small ulcers being left. Much desquamation followed the subsidence of the eruption, the skin of the palm especially being detached in large flakes. As much pain is still complained of, and there has been gradual loss of power in the limb, the patient has continued under treatment.

At present the pain continues severe in the shoulder, arm and forearm, and in the latter situation there is considerable tenderness on pressure. Maculae of a dull red tint mark the seats of eruption above mentioned, and there are two or three small, rounded scars on the forearm and near the elbow. The wrist and hand are much swollen and pit on pressure, especially over the dorsum of the hand; the fingers and thumb are also swollen uniformly, being much larger than those of the right hand. The nails are normal. There is still much old epidermis in process of detachment from the fingers, which are in a permanent position of hyper-extension, so as to give rise to a slight concavity on the dorsum of the hand at the metacarpo-phalangeal joints; the patient is quite unable to flex them, and any attempt to do so forcibly causes great pain. The wrist is also extended and cannot be flexed; the elbow is semi-flexed, but he appears to have hardly any power of moving the joint, although passive motion is painless. The movements of the shoulder are extremely weak and imperfect, but this is probably due rather to the great pain caused by any attempt at movement than to paralysis. There is no marked muscular atrophy as compared with the other arm; occasional fibrillary twitching occurs. Sensation is much impaired; a light touch over the whole of the affected parts is often not perceived at all, while forcible pressure with a sharp point is hardly painful; sensations, when perceived, are localized correctly.

The condition was considered by the exhibitor as probably due to a severe neuritis of the brachial nerves concerned, although some lesion of the posterior spinal ganglia, or perhaps some central lesion, is not excluded.

Dr. CAVAFY also brought forward (2) a case for *Diagnosis*. A widow, aged 37, has suffered from an eruption, limited to the face, for about three months. This first showed itself on the right cheek; the chin, left cheek and forehead becoming gradually affected in the order named. The lesions consist of rounded erythematous patches, half to three-quarters of an inch in diameter, of a dull red colour, and not very sharply circumscribed; the redness disappears completely on pressure. They project slightly above the surface and are discrete, the intervening skin being normal, except on the cheeks, where there is a slight permanent flush. The patches appear slowly, at the rate of one or two a week, and are accompanied by a sensation of smarting and burning; there is no itching. In the greater number a flat vesicle of irregular shape and size appears in the centre, containing a limpid fluid, and rapidly drying up into a very thin crust, the whole lesion slowly subsiding without pigmentation or scarring. The mucous membrane of the lips, tongue and throat is normal, and there are no enlarged lymph-glands. No other part of the skin is affected, and there has been no previous disease of the skin of any kind. Her general health is good, and she had taken no medicine before the appearance of the eruption except a little quinine and iron.

One member present thought the eruption was the result of the application by the patient of some irritant vesicant fluid, but the majority leaned towards the view that it was due to the ingestion of some drug, despite the statements of the patient. The drugs suggested were quinine, chloral and bromides.

Dr. CAVAFY subsequently learned from the practitioner who sent him the case that she had applied to him for "mental worry" on June 20th, and had ten grains of bromide of sodium three times daily till July 1st, when this was altered to the same dose of bromide of potassium till July 10th, the date of the first appearance of the eruption, since which time she had taken no bromide. Despite this history, the following considerations remain very extraordinary: (1) That the affection should continue to appear for quite three

(5) A case of *Dermatitis herpetiformis* in a boy aged 13, who had suffered from the affection since the age of six. At first the bullæ appear to have been large, as the case had been named "pemphigus" by a dermatologist of great experience. Latterly the bullæ had been small and very scanty, while hard large papules and urticarial lesions had predominated, the latter sometimes in the form of Giant Urticaria affecting the eyelids. Unfortunately the case when shown was in a state of almost complete quiescence, only a few trivial urticarial wheals being present.

Dr. THIN showed, for *Diagnosis*, a man, aged 63, who stated that two years ago his general health began to be impaired, and some round, irritable spots developed, first on his neck, and then on his legs and arms. The eruption is now mostly seen on the legs. It consists of round, oval, pigmented patches, of a bluish-brown colour, varying in size from a threepenny-piece to a sixpenny-piece. The skin is smooth to the touch. In some of them there is a slight depression to the finger, as if the skin was partly atrophied. In others an infiltration of the skin can be detected. On the upper part of the front of the right thigh there is a large one about one inch long, three-quarters of an inch broad, and oval in shape, of a bluish colour, the skin over which is loose and thin and silky, and can be easily pinched up; but in the centre under the skin can be felt an uneven, nodular, fibrous-like mass. The patient states that the eruption first appears as an irritable pimple or spot. The irritation soon disappears, and the lesions are never again the seat of any abnormal sensation. None of them have altogether disappeared. On the nates, at the part which would come in contact with a seat, the skin is rough, deeply pigmented, and feels as if there was a depression under the skin, and when touched, gives the sensation as if the tissues under the skin have been absorbed.

On the right hip the pigmented surface is nearly two inches long by about an inch broad. The man complains of a constant pain across the bottom of his back, and his feet are constantly cold. His tendon reflexes are normal.

No definite diagnosis could be made by any member present. The idea of an *Urticaria pigmentosa* developed in adult life, as in one or two cases previously shown at the Society, was mooted, but nega-

tived by the subcutaneous situation of the nodules and the distinct atrophy of skin following their subsidence; nor was there marked factitious urticaria. To some members the idea of a badly-developed form of *withering Sarcoma* suggested itself.

Dr. THIN also brought forward (2) a case of *Lupus erythematosus*, occupying the classical situations on the nose and cheeks, remarkable on account of its close resemblance to superficial cases of *Lupus vulgaris*. The affected parts of both cheeks are very red, turgid, and even to the touch. When pressed by the finger, the skin feels as if considerably infiltrated. Small superficial scars on both ears showed that in these parts the eruption had undergone spontaneous cure. There were a good many outlying, isolated round patches, about the size of a pea, separated from the main seats of infiltration of healthy skin. One small patch of this kind was on the upper lip and reached to the mucous membrane.

The patient was a woman, aged 35, who had always enjoyed good health. Five years ago, spots came out on the nose and cheeks. They spread quickly and coalesced. The disease extended rapidly, and the bat's-wing-shape is now typically developed.

FIFTH CONGRESS OF THE GERMAN DERMATOLOGICAL SOCIETY.

Nothing could be more instructive and agreeable than this Congress, which was held in Gratz, under the genial presidency of Professor Jarisch, on September 23rd, 24th, and 25th. The locality is lovely, and its charm, as well as that of its inhabitants, is not yet blighted by invasions of the tourist mob. The meetings of Congress, which took place daily from 9 A.M. to 3 P.M., were attended by nearly a hundred members and visitors, and the cordial co-operation in their organization of a large number of the students of the University greatly contributed towards their success.

On Monday, September 23rd, after the usual business preliminaries, Professor Kaposi (Vienna) opened a debate upon "*The present Position of our Doctrines regarding Pemphigus.*" His conclusions were summed up as follows:—

(1) Pemphigus is a definite, clinical conception. It is not confined either to special morphological characters (polymorphism), nor to special histological characters (more or less intense participation of the epidermal layers and papillary bodies), but is characterized by the association of these, and by its clinical course.

(2) Our very limited knowledge of the causes of the disease, and our conspicuous ignorance of its ætiology, constitute no argument against the maintenance of the clinical conception of Pemphigus, as our general conception of other skin diseases is of necessity independent of our ignorance of their ætiology.

(3) In one and the same patient, over a period of months and years, all possible forms, modifications, and varieties in the course of Pemphigus can be observed. Hence it follows:—

(4) That the various different types of Pemphigus represent one and the same disease.

(5) That the clinical and histological characters attributed to the chronic, relapsing, benign or malignant, and lethally terminating forms of "*Dermatitis herpetiformis*," correspond in every respect with those formerly observed and described as Pemphigus, and are in fact identical with Pemphigus.

(6) There is, therefore, not the slightest ground for giving up the old-established classical name and morbid conception in favour of the modern "*Dermatitis herpetiformis*."

(7) The acute and benignly terminating disease-processes, referred by some

authors to forms of so-called Dermatitis herpetiformis of Duhring, correspond with diseases formerly well-known and described as Urticaria papulo-bullosa, annularis, gyrata, Lichen urticatus, but especially with Hebra's Erythema multiforme, particularly in its vesicular and bullous forms.

(8) The denomination of Dermatitis herpetiformis applied to these acutely running, papulo-vesiculo-bullous forms of Erythema therefore finds no justification.

(9) I do not know whether there are diseases besides Pemphigus and the other well-known diseases mentioned in which polymorphous erythema and bullæ exist, and which should be designated "Dermatitis herpetiformis." I myself have never met with forms which could not be included under the long-known and accepted title of Pemphigus. I have, therefore, never been compelled to make the diagnosis of Dermatitis herpetiformis or to apply the name to any case.

PROFESSOR KAPOSI stated that his observations were based upon a study of 320 hospital cases, observed from 1860 up to the present, of whom 209 were men, and 111 women, and of at least one-third of that number of additional cases in private practice. His mortality had been 18 to 20 per cent. He maintained that varieties in anatomical form depend upon *intensity* of the pathological process, while the favourable prognosis usually attributed to so-called Dermatitis herpetiformis is erroneous and illusory, referring to fatal cases recently reported.

On very different lines were the conclusions formulated by Dr. O. ROSENTHAL (Berlin), the other official "Reporter." They ran as follows:—

(1) The term Pemphigus designates, according to the present position of our knowledge, no morbid entity, but a definite, elementary form of skin eruption.

(2) The following groups are therefore to be differentiated, which have sometimes been, or might have been, labelled with this designation.

A. Dermatoses which assume a bullous character, owing to some cause not always discoverable, such as Eczema with large vesicles, Urticaria bullosa, &c.

B. Affections in which bullæ develop only as a concomitant or accessory symptom. These constitute a special group, to which the name of Dermatitis bullosa is most appropriately applied.

Such a condition is observed in (a) acute and chronic infective diseases:—Erysipelas, typhus, scarlatina, small-pox, pyæmia, septicæmia, &c. (b) In injuries and inflammations of nerves, *e.g.*, so-called Pemphigus traumaticus, neurotico-traumaticus, neuriticus, tropho-neuriticus, and in central affections, chronic myelitis, tabes, spinal sclerosis, syringo-myelia, &c. (c) After the use of certain drugs: Dermatitis bullosa toxica, or Toxidermia bullosa (Synon.: Toxidermie bulleuse *vel* Hydrotoxidermie [Besnier], Dermatitis venenata [White], Dermatites toxiques).

These bullous forms of drug eruptions, which most frequently have been confounded with Pemphigus, are due to the internal administration of antipyrin or iodine preparations; much less frequently to bromine preparations, arsenic, quinine,

salicylic acid, rhubarb (Litten), copaiva balsam, cinchonine, phosphorus. The affection shows itself by an Exanthema as well as by an Enanthema. With anti-pyrin, apart from the widely distributed form resembling bullous erythema, there occurs the simultaneous involvement of buccal mucous membrane, penis, scrotum, and anus. The observations of Hallopeau and Traferninkow of vegetations after employment of iodine are interesting (*Pemphigus iodicus vegetans*).

(3) *Pemphigus syphiliticus*, which ought to be termed *Syphilis bullosa*.

(4) *Pemphigus leprosus*, for which a better name is *Lepra bullosa* and bullous neurolepride (Unna).

(5) *Dermatitis bullosa hysterica* or *Pemphigus hystericus*. This may result from trophic disturbances in the course of hysteria, or is a simulated dermatosis, or *Dermatitis artefacta*. *Pemphigus virginum* (*des jeunes filles*) may be attached to *Pemphigus hystericus*.

(6) *Erythema bullosum* (*Erythème polymorphe vésiculo-bulleux*; *Erythema bullosum*); this is a form of *Erythema exsudativum multiforme* (Hebra), and therefore, as well as other forms immediately to be mentioned, stands in the same relation to various ætiological conditions, and shows the same clinical characteristics as *Erythema exsudativum multiforme*. There is no doubt that many cases of *Erythema bullosum* have been erroneously considered and described as *Pemphigus circinatus et gyratus*. Bullous erythema of the mucous membrane of the mouth is often accompanied by a similar affection of the penis, scrotum and anus. (The terms *Hydroa buccal* [Quinquaud] and *Hydroa buccal pseudo-syphilitique* [Baudouin] are unnecessary.)

(7) *Herpes iris* (Bateman) and *Circinatus* (*Hydroa vésiculeux aigu* of Bazin; *Hydroa vrai* of Brocq). This form belongs, as has been mentioned, to *Erythema multiforme exsudativum*, both as regards origin and clinical characters. The literature includes several cases which must be referred to *Dermatitis herpetiformis*. The limits must, therefore, be more accurately defined to correspond with the name; instance must be laid upon well-defined iris or circular conformation, symmetry, colour, preference for definite localizations and certain seasons, tendency to relapse at certain times, &c.

(8) *Hydroa vacciniforme*, or preferably *Varioliforme* (Bazin), Summer eruption (Hutchinson), *Eruptio æstivalis vacciniiformis* (Brocq), *Erythema solare* (Kaposi). These affections, first recognized and described by Bazin, have, as characteristic clinical features, the active part played in their production by the sun's rays, their incidence upon uncovered parts of the body, their beginning and often terminating in childhood, their frequent relapses, their preference for the male sex, and the tendency of the eruption to leave pits with consecutive necrosis extending into the papillary layer.

(9) *Epidermolysis bullosa hereditaria* (Köbner), to which the names *Pemphigus hereditarius*, *Dermatitis bullosa hereditaria*, and *Acantholysis bullosa* have been applied, but with less propriety. In this affection there is a congenital and hereditary diminution of the resisting and cohesive power of the epidermis, especially of the prickle-cell layer, as the result of which the slightest lesion produces an effusion of serum. It is doubtful whether there is any underlying *Dysplasia vasorum* (Blume, Klebs).

(10) *Dermatitis exfoliativa neonatorum* (Ritter). Synonyms: *Febris epidermica contagiosa*, *Pemphigus acutus contagiosus neonatorum*, *Pemphigus epider-*

micus neonatorum (Brocq), Pemphigus acutus benignus afebrilis (Unna), Pemphigus acutus neonatorum (Besnier, Doyon). The affection is epidemic, contagious, inoculable even upon adults, and auto-inoculable. The course of the disease is generally benign. In most cases the palms and soles are unaffected. The affection is different from Impetigo contagiosa, but difficult to distinguish from the epidemic form of that disease. The ætiology is not yet cleared up, but it is more probable that it is due to some mould-fungus than to a coccogenic (*Diplococcus*) infection.

11. *Dermatitis herpetiformis* of Duhring. The establishment of this affection is to be regarded as an advance, with its various characteristic forms and clinical features, which we owe chiefly to Duhring and Brocq—viz., polymorphism, paræsthesiæ, tendency to relapse, comparatively good general condition. Three forms are distinguished: (a) acute, (b) subacute, (c) chronic. To this group belong the diseases described under the following names:—Hydroa bulleux and Hydroa arthritique (Bazin), Herpes pemphigoides (Devergie), Pemphigus circinatus (Rayer), Herpes circinatus bullosus (Wilson), Pemphigus pruriginosus (Chausit, Hardy), Hydroa pruriginosum (Tilbury Fox), Pemphigus diutinus pruriginosus à petites bulles, Pemphigus compositus, and other widely separated chronic diseases described as Pemphigus and Herpes iris. Although the name "*Dermatitis herpetiformis*" does not disclose the nature of the disease, still it seems wiser to stick to this nomenclature for the present, as all other proposed alterations are unsuitable on various grounds. Such are *Dermatite polymorphe douloureuse à poussées successives* (Brocq), *Dermatite herpétiforme récidivante* (Vidal, Leloir), *Dermatites bulleuses complexes* or *multiformes idiopathiques primitives* *vel* *Hydrodermies multiformes* (Besnier, Doyon), *Hydroa mitis* and *Hydroa gravis* (Unna), *Dermatitis multiformis* (Allen, Sherwell, Piffard), *Hydroa pruriginosum* (Köbner), *Dermatitis pruriginosa* (Bulkley), *Dermatitis tropho-neurotica* (Morrow), *Hydroa herpetiformis* (Crocker), *Dermatitis multiformis neuritica*, *Hydroa pemphigoidé* (Quinquaud), &c.

Histologically, according to various investigators, an elevation of all the epidermal layers down to the papillary body can be observed in the formation of the majority of the bullæ. No particular differential value can be attached to this circumstance, as a similar state of things is present in ordinary Pemphigus and in the formation of blebs in general, differences correspond with anatomical characters and the acuteness and intensity of the process.

The Ætiology is unknown—bacteriological research has proved negative—still it appears very likely that a prominent part in the pathogenesis is played by the nervous system (Dermatoneurosis of peripheral or of central origin). It is undetermined whether toxic influences are at play. Therapeutics is powerless. Arsenic internally, sulphur and tar externally, are the most efficacious of all remedies.

It must remain for further investigations to decide whether the *Hydroa puerorum* (Unna), *H. juvenum* (Pringle), with the clinical peculiarities attributed to it by Unna, ought to be regarded as a special sub-species of *Dermatitis herpetiformis*.

The *Dermatite pustuleuse chronique à progression excentrique* (Hallopeau) may perhaps possibly stand in close relation to *Dermatitis herpetiformis*, to *Herpes iris* or *Impetigo herpetiformis*.

(12) *Herpes gestationis*, Synonyms:—Dermatose herpétiforme récidivante de la grossesse (Vidal and Leloir), Dermatite polymorphe douloureuse subaigue récidivante de la grossesse (Brocq), Pemphigus acutus pruriginosus (Chausit), Dermatitis multiformis gestationis (Allen), Hydroa graviditatis (Unna). Although Herpes gestationis stands in very close connection with the vesicular form of Dermatitis herpetiformis, and perhaps belongs to it, still it seems advisable for the present to regard the ætiological factor as causative of the eruption, and to have this particular name attached to this form of dermatitis of the gravid state.

(13) *Impetigo herpetiformis* (Hebra, Kaposi). This is a disease with regard to which it is not yet decided whether it depends upon a metastatic, pyæmic, or upon a neuro-reflex process. The affection, with very rare exceptions, occurs during pregnancy or the puerperium. Its character is malignant. It is worth mentioning that the eruption tends prematurely to interrupt the pregnancy.

(14) After the elimination of these groups (2 to 13) there still remain a number of cases which are distinguished by a continuous or intermitting outbreak of single or composite blebs, with contents at first serous, the base of which is not at all, or only slightly, reddened. In these cases there is neither conspicuous polymorphism, nor arrangement in circles or crescentic lines, and paræsthesiæ are not prominent symptoms. Of these there may be distinguished:—

A. *Pemphigus acutus* (Febris bullosa seu pemphigosa seu ampullosa; Erythema exsudativum infectiosum). This in its course resembles an infectious disease with prodromal period, rigors, high fever and further developments, and ends generally fatally in a week or a fortnight. Sometimes it runs its course as a *Pemphigus acutissimus* in twenty-four hours to three days. Although objection may be raised to the diplococci already involved as the exciters of the disease (Demme, Strelitz, Fabes, Claessen, Bleibtreu, &c.) still the impression is borne out by its course that it is an infectious septicæmic process. The contents of the bullæ are often hæmorrhagic.

B. *Pemphigus vulgaris*. (a) *Pemphigus vulgaris subacutus*. The duration and course of many of the cases described in literature justify the establishment of this sub-species.

(b) *Pemphigus vulgaris chronicus*, from which *Pemphigus solitarius* is to be separated. *Pemphigus crouposus* and diphtheriticus are dependent probably upon some superadded bacterial infection.

The subdivision proposed by Nodet into Affections pemphigineuses, pemphigoides, &c., is too systematic.

So-called *Pemphigus conjunctivæ* is probably an affection more closely connected with essential shrinking of the conjunctiva and leading to Phthisis bulbi, which ought to be separated from *Pemphigus vulgaris*. Occasional localization on the conjunctivæ in *Pemphigus* of the skin does not lead to permanent changes.

In all forms of *Pemphigus* mucous membranes may be involved. In many cases, and indeed more frequently than one could justifiably conclude from the literature of the subject, the mucous membranes are first, and often for a long time, alone attacked, in which circumstances the resistance to therapeutic measures contributes towards supporting the diagnosis, e.g., in differentiating from Erythema bullosum mucosæ. The bullæ of *P. vulgaris* are generally single-chambered, and are situated under the horny layer, the base being in the prickle layer. The ætiology of these forms is unknown.

The examination of the blood, of the contents of the bladder, and of the urine, from the chemical, microscopic, and bacteriological points of view, has yielded no positive results. The increase in number of eosinophile cells does not necessarily indicate that the skin participates in the formation of these cells. It may be assumed, however, that, as in the case of *Dermatitis herpetiformis*, one is not dealing with a direct vasomotor or trophic neurosis. The anatomical changes hitherto noted in the nervous centres cannot be claimed to have any causal value, as they differ widely in their characters and localization. The prognosis is generally favourable in the subacute forms, but less so in the chronic ones. Transition into *Pemphigus foliaceus*, with severe, general, or local symptoms (e.g. persistent participation of the buccal mucous membrane, involvement of the intestinal tract), aggravates the prognosis. As regards treatment, the continuous bath and arsenic merit special mention.

C. *Pemphigus foliaceus*. This either starts as such immediately or develops out of a *Pemphigus vulgaris*. To this type belong: chronic, bullous, and exfoliating dermatitis, and congenital *Pemphigus foliaceus* (Besnier). In the exfoliative condition a very marked persistent dilatation of the vessels is produced by their paralysis, especially of the subpapillary lymph-vessels with oedematous saturation of the true skin.

D. *Pemphigus vegetans*. This must be regarded as a special sub-species of the preceding forms most closely related to *Pemphigus foliaceus*. The denomination of *Erythema bullosum vegetans* (Unna) has no indications for its employment. The histological conditions found—e.g. arteritis and phlebitis obliterans of the subcutaneous tissue and skin, enormous dilatation of the papillary vessels, proliferation of the rete and papillæ—have no pathognomonic importance. Bacteriological research has been hitherto negative. Possibly it may be the result of secondary bacterial infection. The luxuriant vegetations which are chiefly localized on surfaces in contact are similar to those which occur in other skin diseases (? mixed infections). The prognosis is almost absolutely lethal. The conditions hitherto found in the central organs are probably secondary, as are probably the symptoms observed in connection with the spinal cord. Mechanical removal of the growths and tincture of iodine appear to be therapeutic measures of value.

It is not proposed to consider the *Herpétide maligne exfoliatrice* consecutive to a *Pemphigus* (Bazin), or to a *Dermatitis herpetiformis* (Brocq). [*Erythrodermie exfoliante* (Brocq), *Dermatite maligne chronique exfoliante* (Vidal and Leloir).] As a phase worthy of a special name or as an intermediate stage between *Pemphigus* and another affection.

(15) There must still be mentioned a form of congenital bullous inflammation of the skin which is difficult to classify, which according to various authors' views has nothing in common with *Pemphigus vulgaris*, but must be referred to trophic disturbances. It has almost as many names as there are cases described: *Dermatite bulleuse infantile avec cicatrices indélébiles et kystes épidermiques* (Hallopeau), *Dermatitis bullosa congenita infantilis à kystes épidermiques* (Besnier), *Pemphigus successif à kystes épidermiques* (Brocq), *Lésions trophiques d'origine congénitale à marche progressive* (Vidal), *Ichtyose à poussées bulleuses* (Besnier). No pathognomonic significance can be given to these epidermic cysts, which occur in other affections.

(16) The foregoing classification, which is based chiefly on clinical characters, does not exhaust the question of the bullous skin diseases. There exist a number of transitional forms between several of the affections mentioned and related dermatoses, especially between Dermatitis herpetiformis, chronic Pemphigus and Pemphigus foliaceus; between Dermatitis herpetiformis papillomatosa and Pemphigus vegetans; between Dermatitis herpetiformis, Urticaria bullosa, chronic Urticaria, and certain forms of Pruritus; between Dermatitis herpetiformis and Impetigo herpetiformis; between Dermatitis herpetiformis, chronic Pemphigus, Erythema bullosum, and Herpes iris.

Dr. EPPINGER (Graz) read a paper on the *Pathological Anatomy of Pemphigus*, founded on the examination of six cases, two of which were examples of Pemphigus foliaceus. He found that the covering of the blebs were not always the same: the prickle layer, however, always perished, although sometimes undergoing degenerative changes. Changes in the epidermis in the neighbourhood of the blebs with œdema of the skin were always present. The blood-vessels were constricted—not dilated, as generally believed—and both sweat- and sebaceous-glands sometimes showed changes. No changes were found in the main nerve-trunks, but in the peripheral nerves pathological conditions could be demonstrated by Wolter's method, *e.g.*, simple degenerative changes at the base of the bullæ with hæmorrhage round, and inflammatory changes in, other peripheral nerves. In the spinal column he had observed degeneration of cells in the anterior columns and intermeningeal hæmorrhages.

He also described two epidemics of Pemphigus neonatorum which had occurred in Graz, all being of mild type, and five cases of Dermatitis exfoliativa in young children observed in the last few years, invariably between May and August, all of which had begun by an eruption of bullæ lasting two or three weeks. Then the epidermis became sodden and could be picked up and detached in long strips. The disease could only be confounded with Ichthyosis congenita sebacea.

Dr. Eppinger concluded that Pemphigus was not a bacteriological disease, but probably the result of a toxic poisoning. He demonstrated (1) A case of so-called Pemphigus—or essential shrinking—of the conjunctivæ in an old woman who had had no true Pemphigus manifestations elsewhere on the skin, and (2) A man with Pemphigus of the axillæ, penis and mucous membrane of the mouth.

Prof. PETRINI (di Galatz) did not admit Pemphigus acutus as a distinct disease, nor P. syphiliticus, nor P. traumaticus. He makes the diagnosis of Dermatitis herpetiformis in certain cases merely because it is the fashion to do so. He thinks Hydroa a different thing, and regards true Pemphigus as a grave and fatal disease.

Prof. SCHWIMMER (Buda Pesth) adopted views intermediate between those expounded by Kaposi and Duhring. He thought both Pemphigus and Dermatitis herpetiformis undoubtedly of nervous origin, but based his opinion as to their being different diseases mainly on their different prognosis.

Prof. NEUMANN (Vienna) recognized Pemphigus acutus as a distinct disease, as also P. vegetans. He thought P. foliaceus was merely Pemphigus occurring in badly-nourished individuals, and he had never felt the necessity of making a diagnosis of Dermatitis herpetiformis.

Prof. NEISSER (Breslau) thought that the expressions of opinion on both sides were exaggerated. He deprecated the tendency to invent new names and new

diseases characteristic of the modern Paris school. He had frequently, however, met with cases which did not accord with the classical conception of Pemphigus, and which he regarded as Dermatitis herpetiformis. He put a direct question to Prof. Kaposi as to his conclusion (No. 8), whether he had ever seen a single case which had gone through the phenomena attributed to Dermatitis herpetiformis to become one of true Pemphigus.

After remarks from Dr. Westberg (Breslau), and Dr. Kopp (Munich), who referred to the simulation of Pemphigus by Syphilis, Prof. Kaposi replied in humorous fashion, saying that in the case of a patient who was always laughing he had made the diagnosis of "Pemphigus hilaris" !

J. J. P.

(To be continued.)

CURRENT LITERATURE.

HYPERKERATOSIS ECCENTRICA. Dr. E. RESPIGHI, Pisa (*Il Giorn. ital. delle Mal. Ven. e della Pelle*, Fasc. I., 1895.)

THE patient, a male, ætat. 66, was in otherwise good health, and never had syphilis. A typical efflorescence was papular, millet-seed in size, slightly pigmented, and of a horny consistency. These efflorescences were either single or arranged in various figures: guttate and discoid, annular and circinate. In the discoid shape the efflorescences formed a central horny mass, surrounded by a well-defined sulcus, the external margin of which gradually passed into the surrounding skin. In the annular type the centre was atrophic, and the margin formed by a ring of efflorescences, and these in turn were sharply defined by a sulcus from the healthy skin. There were no signs of inflammation at any time, and the efflorescences never passed into a vesicular, pustular, or ulcerating stage. The principal sites of the eruption were the extremities of the limbs, especially in the regions subject to pressure; here it was grouped. The nails were also implicated, the nail-bed was thickened, raising the nail considerably. There were also solitary and grouped efflorescences scattered over the trunk. The mucosæ were not affected, and the lymphatic glands were not enlarged. The affection began forty years ago, but never caused the patient much inconvenience. Examination of the internal organs revealed nothing abnormal. It was evident that the eruption spread eccentrically. Its evolution was exceedingly slow, as the patient noticed it first when twenty-six years old. Although the pressure areas—palms and soles—caused most inconvenience, the eruption extended to the dorsum of hands and feet, where the epidermis was not so indurated as in the former areas.

Microscopic examination of a portion of an annular type of the efflorescences, including the central atrophic area, revealed the following changes:—The horny layer of the efflorescence was considerably increased, that of the central area on the other distinctly diminished. The prickle-layer corresponded. The papillary layer of the derma was almost obliterated in the central area, in which here and there the remains of a sweat-duct could be recognized; the pars reticularis was also much less in depth than normal. The peripheral zone where the efflorescences were, showed marked hypertrophy of the papillæ and keratosis of the tubular ducts, so that these were dilated, and their orifices distended with horny epithelium. In the pars reticularis the blood-vessels were dilated and outlined at intervals by a round-celled infiltrate. The sebaceous follicles also showed accumulation of epithelium at their mouths.

Dr. Respighi considers this affection never to have been described before, and he devotes a good many paragraphs, which need not detain us, to refuting the suggestion that it is an "autotoxic kerato-dermatitis" (Tommasoli), or a form of ichthyosis

partialis cornea, &c. All this does not add one iota to our knowledge ; in fact this wrangle over terminology helps to confuse what little we already know, and merely impedes progress. Although Respighi admits the possibility of the disease—he was unable to examine a primary efflorescence—starting in the sweat-pores, he objects to the term “porokeratosis,” as that might lead one to think it only affected the orifices of the sweat-glands and did not implicate the intervening skin. He lays stress on the fact that the disease spreads centrifugally, involving all epidermal structures, and leaving an atrophic area in the centre ; hence his adjunct “eccentrica.” Although he stained for micro-organisms and made experiments of transplantation of efflorescences, he obtained no proof that it was of a parasitic nature. There is no objection to drawing attention to the clinical appearance of this “form” of keratosis, but there is surely no reason to connote it by a special epithet—seeing that the pathology of the disease is that of a keratosis pure and simple. The less we have of double-barrelled names in dermatology the better.

FRANK H. BARENDT.

LICHEN PLANUS WITH BULLÆ. By M. LEREDDE. (*Annales de Dermatologie et de Syphiligraphie*, July, 1895.)

MME. M., æt., 48 years, laundress, a nervous woman, with distinct hysterical tendencies, was anæmic, and had suppression of menses since 28 years of age. During the last five years has suffered from phlebitis of right leg, and lately a varicose ulcer ; has also had a “pleurisy,” but her general condition of health remains good except for anæmia and nervousness.

The eruption began in the left leg five weeks ago, and was accompanied from its origin by bullæ, which have even been more abundant than at present. Itching has been little marked. The eruption now occupies the forearms and backs of the hands as abundant typical papules ; the thighs, as irregular plaques and papules ; and the legs and dorsum of the feet as abundant isolated papules ; the palms and soles are the seat of small patches of keratosis ; on the trunk, the sub-mammary folds, and the abdomen, and the waist there are numerous plaques and papules. At a fold in the obese abdomen and in each ham are large, non-raised, deeply pigmented patches.

On the front of the left wrist is a raised violaceous plaque, which has at one point a lesion due to a vesicle of the size of a lentil. The vesicle has dried, leaving a light peripheral desquamation.

On the lower limbs there are still some bullæ to be seen, represented by ulcerations of varied dimensions, either purulent or covered with a central crust. These, when seen at an earlier period, were observed to take origin from the confluent plaques of lichen, or in the hams on the pigmented patches, and were, from their first appearance, distended with a clear, viscous alkaline liquid.

The mucous membranes were not involved.

In some remarks upon this case Leredde observes that these rarely described cases suggest at first some association of Duhring's dermatosis with Lichen planus. Examining the blood and liquid from the bullæ, he found eosinophilic corpuscles present in the former but not in the latter. In the former disease, however, Leredde and Perrin (*Annales de Derm. et de Syph.*, April and May, 1895)

had found eosinophilic bodies in the liquid of the bullæ as well as in the blood. Leredde argues, therefore, that the bullæ in this case cannot be regarded as those of *Dermatitis herpetiformis*. But the eosinophilic bodies in the blood, together with the presence of anæmia and the absence of catamenia, show that there is present a "profound alteration in the blood," and suggest that the eruption may be due to hæmic trouble, itself perhaps of nervous origin. He pleads for more careful study of the blood alterations in cases of *Lichen planus*, for, in his opinion, they form a pathogenic link between certain nervous troubles and cutaneous lesions. He expresses the opinion that *Lichen planus* is a universal affection of the skin and mucous membranes, and puts forward a modified form of the theory of Jacquet. The altered conditions of the skin and mucous membranes are not at first, and never wholly apparent. The apparent lesions are only determined by scratching and by cutaneous traumatism, and the itching does not precede the lesions, as is the view of Jacquet, but simply precedes the apparent lesions, *i.e.*, the eruption. The itching is due to the already altered dermic conditions, to a toxic substance present or circulating in the skin.

H. G. ADAMSON.

A PATHOGNOMONIC SIGN OF LICHEN PLANUS OF WILSON.

LOUIS WICKHAM. (*Annales de Dermatologie et de Syphiligraphie*, June 1895.)

WICKHAM lays great stress upon the importance of "grey points and striæ" as an additional diagnostic sign of *Lichen planus*. He observes, that this sign is not even mentioned by the majority of authors, and he has only found definite (though brief) references to it in the text-books of Ziemssen, Hardy and Brocq.

The "grey points and striæ" are most readily observed in typical "adult" papules, where one perceives on close examination that the plane surface is made up of two distinct parts of different colour, *viz.*, a rose ground with grey striæ or grey points. The proportion between the two parts and the arrangement of the grey portion may be very variable. Among the more usual arrangements are the following:—The grey element may stripe the whole surface of the papule, either as small bands forming stars or as a central band with lateral shoots, or there may be a single grey band, or a large central wafer-like patch, or a ring of grey, or sometimes numerous grey points, or points in a row, as though about to form a stripe.

The striæ are less distinctly seen on the earlier papules, but are very evident on the larger plaques formed by the coalescence of adult papules. They are usually on a level with the pink portion, though on the plaques they may be in slight relief. The grey portion has greater brilliancy than the pink, and this would seem to be the cause of the characteristic shining appearance of *Lichen planus* papules. The grey striæ and points may perhaps be regarded as analogous with the points and striæ of planus of mucous membranes.

Though most easily seen in typical papules, the grey markings can often be found in atypical forms, and then it is that they are of so great value as a diagnostic sign; for although there are many cases of *Lichen planus* in which this sign is absent, yet if it be present it may be regarded as pathognomonic of that disease.

H. G. ADAMSON.

PERSISTENT ERYTHEMA DUE TO ANTIPYRIN. W. DUBREUILH.
(*Archives Cliniques de Bordeaux*, August, 1895.)

IN March, 1894 (*Annales de Dermatologie et Syph.*, Vol. V. p. 303), under the title "Éruption Érythémato-pigmentée fixe," Brocq drew attention to a form of antipyrin eruption characterized by single or not very numerous infiltrated, raised persistent plaques, appearing at the same place, each time the patient had taken antipyrin. Brocq described three cases which had come under his observation, and referred to previously published similar cases. Dubreuilh here relates a corresponding example. The patient, a lady, aged 35, had been accustomed to take antipyrin for neuralgia, at intervals of two or three months. Shortly after each dose there appeared on the left cheek a red itching patch, which rapidly became infiltrated, forming a pale, brownish-red, raised, clearly limited plaque with deep diffuse infiltration. The plaque, which measured 15 m.m. in diameter, became fully developed in a few hours, remained for some days, and as quickly disappeared, but leaving a bistre-coloured macule, which persisted from one outbreak to the next. After the most recent dose a second plaque appeared on the forehead to the left of the middle line. The eruption gave rise to no pain, and when developed to no itching. During the last twelve months the patient has taken no antipyrin, and has had no further outbreak, but the brown macules at the seat of the plaques have not yet disappeared.

H. G. ADAMSON.

ECCHYMOSES IN INSANITY. W. R. DAWSON, M.D., Dublin. (*Dublin Journal of Medical Science*, August, 1895.)

DR. DAWSON relates an unusual case of purpuric eruption occurring in a woman who suffered from delusional melancholia. The patient had for five years been subject to frequent periodical attacks of "violent, angry excitement." During the last fifteen months each of these attacks, which occurred at intervals of two to four weeks, had been associated with an eruption of spots varying greatly in number, size and position. They favoured somewhat the extremities, and on two occasions the mucous membranes were affected. The larger spots varied in size from that of a threepenny-piece to an inch square. During the first years of the illness the fits had been frequently followed by an eruption of erythematous patches on the chest and limbs, but there had been no hæmorrhage until more recently.

The author discusses the pathology of cutaneous and subcutaneous hæmorrhages in nervous diseases and criticizes the view of Unna, that ecchymoses of nervous origin are due to a combined active and passive congestion, without influence of disease of the vessel walls. If this were the case, ecchymoses would be more common. That hæmorrhages may occur from congestion alone, he admits, *i.e.*, in epilepsy, but here they are usually small and the congestion is of the extremest possible form. Apart from epilepsy, ecchymosis may occur in hysteria, locomotor ataxy, and in insanity. In the two former, some other factor than congestion seems necessary to explain the phenomena, and this is probably a combination of vessel degeneration and blood change. It is in insanity, however, that one would expect the clearest evidence of degeneration and the greatest frequency of ecchymosis, and although a very small number only of such cases have been recorded (apart from

hæmorrhages due to scurvy), yet the example here published seems to be explicable upon no other hypothesis. Although the patient had been subject to fits for five years, no actual hæmorrhages had occurred until four years after their commencement, and since then have invariably accompanied them, "facts which compel us to assume the existence of some gradual vascular degenerative process."

H. G. ADAMSON.

TUBERCULAR LUPUS ASSOCIATED WITH SMALL, PAPULAR SYPHILIDES. PROF. PETRINI, de Galatz. (*La Presse Médical Roumaine*, No. 23, 1895.)

THE patient, aged 22, was fairly well-developed, but anæmic and of "lymphatic constitution." There was some evidence of tubercle in his family, viz., an aunt had died of phthisis, one sister suffered from enlarged glands, and five brothers had died in infancy. The lupoid lesions on the face, on the left thigh, and on the right buttock, dated from one year of age. Three months ago he had had a chancre on the penis, and six weeks ago an almost general eruption of small papules had appeared on the trunk and limbs. The whole of the right side of the face was occupied by a patch made up of lupus nodules and scar-tissue. On other regions of the face were ulcerating scrofulo-tuberculous gummata, and there were enlarged glands in the neck. On the right buttock were two lupus patches, and on the left thigh a small ulcer and a scar.

Microscopical examination of two nodules from the face showed the characteristic appearances of lupus lesions, and tubercle bacilli were found in the discharges from the ulcerated surfaces. The syphilitic eruption consisted of very small smoked-ham-coloured papules, with a tendency to be confluent in certain regions. This cutaneous eruption covered the whole surface, with the exception of that of the face, of the neck, hands and feet. The eruption was perfectly symmetrical. It caused no itching. There were mucous patches upon the tonsils, fauces and soft palate, and glandular enlargements in the cervical region and groins.

The papular eruption was unusual in that it showed no tendency to polymorphism, that the papules were quite small, and that the period of its devolution, under administration of mercury, was considerably longer than is generally the case with secondary syphilitic eruptions.

H. G. ADAMSON.

XANTHOMA DIABETICORUM. JAY F. SCHAMBERG. (*Journal of Cutaneous and Genito-Urinary Diseases*, May, 1895.) (With plate and micro-photograph.)

THIS case, reported from Philadelphia, is the third published observation in America. The patient, C. K., aged 84, a native of Germany, had always enjoyed good health and only presented himself on account of the skin affection. The character of the eruption directed attention to the urine. The examination showed an abundance of sugar and a very small amount of albumen. On further examination it was found that there had been considerable loss of body weight during the last two years, together with thirst and polyuria.

The eruption consisted of pin-head to pea-sized, discrete, dull-red to yellowish-

red papules, with small dilated capillaries seen on close inspection. The eruption was distributed as follows:—Flexor surface of left arm, of right forearm, back of neck, anterior and posterior axillary folds, loins, buttocks, and thighs at upper part. Two or three papules on dorsum of left hand and one on palm of thumb. Face and mucous membranes free. On the left elbow was a patch made up of coalesced papules. The only subjective symptom was some tenderness of the lesions.

With an anti-diabetic regimen and the administration of jambul and codeine the lesions, which had previously been increasing in number, immediately began to fade, and finally, after some weeks, scarcely a trace of the eruption remained.

Microscopical examination of an excised papule revealed a dense, sharply circumscribed infiltration of leucocytes and fusiform connective tissue cells, involving the papillary body and extending deeply into the corium. The papillary vessels were dilated. There were also scattered groups of large epithelioid cells, many multinucleated, the so-called xanthoma giant cells. The sweat-glands and ducts, and the hair-follicles were invaded in the general cell infiltration.

H. G. ADAMSON.

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A NOTE ON THE PERMANENT STAINING OF RINGWORM FUNGUS.

BY H. G. ADAMSON, M.D. (LONDON), M.B.C.P.,

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THE difficulty of obtaining permanently stained specimens of hairs, nails, and horny epidermic scales attacked by the parasitic *Hyphomycetes* has been noted by all who have occupied themselves with the study of parasitic fungi diseases. At the present time there exists no wholly satisfactory elective staining method, by which the fungus can be clearly differentiated from the surrounding tissues, although, however, some important improvements have been recently introduced by Unna and Waelsch.

The need of some such method is recognized. Sabouraud in his recent work* remarks that a "collection of permanent preparations concerning the external mycoses" is necessary for the following reasons:—

1. To be able to recall, when one examines the correct morphology of a trichophyton in the hair, whether a previous case examined presents an exactly identical form.
2. To recall, in the case of an adult cultivation, the microscopical aspect which has furnished it.
3. To compare at the same time the different morphology of fungi during parasitic life, when the cultures obtained from them have proved different.

* "Les Trichophyties Humaines." Paris, 1894.

The difficulties with regard to stained specimens arise chiefly from the fact that the ordinary methods used for the demonstration of bacteria are almost useless in the case of horny tissues. The keratin of which these structures are composed is found to keep the stain as firmly as the fungus, so that the decolorizing agents usually employed either do not remove the stain at all, or else withdraw it both from the tissue and from the fungus.

To overcome this difficulty, various reducing agents have been employed, by which the composition of the keratin is so altered that it more readily decolorizes. Bœch (1835) employed resorcin for this end. Unna* has introduced a modified form of Weigert's fibrin stain, replacing the iodine and iodide solution of Gram, by a mixture of peroxide of hydrogen and 5 per cent. iodide. The peroxide of hydrogen acts in a similar way to the resorcin of Bœch, *i.e.*, as a reducing agent. Unna has further improved upon this method by the addition of an acid stain to the anilin, "by which means the decolorizing power of the anilin over the iodine stained basophilic organisms is weakened, and its power over the iodine-stained acidophilic surroundings is strengthened — so that the elective colouration of the organisms is greatly improved."

Waelsch,† for the staining of the fungus of favus, has employed the ordinary Gram-Weigert method, adding to the anilin oil 1 per cent. of hydrochloric acid. By so doing the decolorizing power of the anilin is greatly enhanced, the added hydrochloric acid enabling it to remove the stain from the horny structures even more effectually than does the mixture of anilin and acid stain of Unna.

With this method Waelsch has obtained most excellent results, as shown in the plates accompanying his article; and for the staining of the fungus in sections, or in their scales and slender hairs, the process may be regarded as perfect.

To both these staining methods the objection may be made, that though suited for sections or thin scales, they are less useful for thick scales and for hairs, since these latter can only be compared to thick sections, often presenting several layers of fungus, so that for the demonstration of the anatomical relations of the fungus

* "Natürliche Reinculture der Oberhautpilze," *Monatsheft f. Prak. Derm.*, Bd. XVIII., No. 6.

† "Zur Anatomie des Favus," *Archiv. f. Derm. u Syph.*, Vol. XXXI., 1, 1895.

to the hair they are far less useful than fresh specimens prepared with solution of potash. In these latter the cover glass exerts just sufficient pressure upon the softened hair to flatten out the specimen without destroying the true relations of the fungus and the hair and moreover, the horny elements of these structures are rendered so transparent by the potash that even fairly thick specimens can be accurately examined by focussing through.

Sabouraud, in his work "*Les Trichophyties Humaines*," advocates the employment of the solution of caustic potash method as the best suited for the study of these parasites in their relations to the invaded structures. He observes, "the extemporized preparation thus obtained will give most useful information."

- (1.) As to the habitat and general arrangement of the parasite.
- (2.) As to the exact morphology of each parasitic element.
- (3.) As to the relations of the elements to one another. "While few only of these points can be made out in the ordinary stained specimen."

Attempts to obtain permanent specimens by mounting the potash-treated hairs and scales in glycerine or Farrant's solution have proved unsatisfactory. The refractive indices of some of the fungus elements and of these mounting fluids are so nearly equal that such elements disappear from view in specimens mounted in them.

Mibelli in his recent work upon the trichophytens has employed the liquor potassæ method, and I have myself till recently been forced to fall back upon the somewhat unsatisfactory proceeding of photomicrography in order to obtain permanent records of such temporarily mounted preparations.

Latterly, however, I have employed the method which I am here about to describe, and which consists of a combination of the two processes, viz., *the application of caustic potash solution followed by an ordinary staining method.*

Under the influence of the potash solution the horny structures swell up and become softened, and at the same time lose their keratin nature, so that they subsequently decolorize readily, as do other non-horny epithelial tissues.

The previous use of potash, moreover, enables one to first examine the specimen in the ordinary way, and afterwards to secure a permanent record of any appearance desired.

The details of the method are as follows :—Specimens of hair, or of scales, are placed on a slide and covered with a drop of a 5 to 10 per cent. solution of caustic potash and a cover glass applied, as described in my paper in an earlier number of this Journal. They may remain here for from ten minutes to half an hour, according to the rapidity with which the clearing takes place, or according to the particular appearances one may wish to record. For example, if one desires to show the fringe of mycelium at the neck of the soft bulb in either of the varieties of ringworm, the potash should only be employed for a few minutes, as also in the case of ringworm of the beard, where the external "sheath" is to be demonstrated. When one intends to stain the fungus within the hair in the endothrix forms, or in the thick hairs from the beard, the specimens must soak for a longer period. Again, for staining the elements of the fungus simply, without regard to their relations to the hair, a longer period is required, and the specimen may also be flattened out by pressure of the cover glass.

The "clearing" having reached the desired stage, the next step is to fix the specimen and prepare it for mounting. This is done by gently washing under the cover-glass a few drops of a 15 per cent. mixture of alcohol in water. The alcohol mixing with the potash solution hardens the specimen sufficiently to prevent its destruction during the removal of the cover-glass. In the case of scales these will remain adherent, either to the cover-glass or to the slide, while a hair usually floats, and must be left behind by the removal of the alcohol with blotting paper. Any excess of potash is then washed off with more 15 per cent. alcohol, and the slide or cover-glass bearing the specimen is dried over the flame. Where scales are being prepared, they can be fixed to the glass by passing two or three times through the flame, as in the examination of blood or sputum. The specimens are now ready for staining, and this is best carried out by the ordinary Gram-Weigert method. If a counter stain is desired, one may add eosin or picric acid to the anilin, as in Unna's method. The staining and decolorizing is done entirely on the slide or cover-glass, and it is convenient to temporarily "mount" the specimen in the clearing agent, so that this process may be watched and prevented from going too far, *i.e.*, to decolorization of the fungus. The length of time during which the staining and decolorizing agents are employed

will vary greatly with the extent to which the softening action of the potash has been allowed to advance. Where this has been of long duration, a few minutes only in the stain, and from 15 to 30 minutes in the anilin, will be found sufficient. When the potash solution has been used only for a few minutes, the staining and decolorizing processes both require a longer time, *viz.*, from half an hour to an hour, or longer, for the staining, and from two to three hours, or longer, for the decolorizing.

The general method of procedure then is as follows:—

1. 5 per cent.—10 per cent. solution of caustic potash on the slide—10 m. to 30 m.
2. Wash in 15 per cent. alcohol in water.
3. Dry on the slide, and, in the case of scales, fix by passing through the flame.
4. Stain in gentian-anilin-violet (made in the usual way by the addition of a few drops of saturated alcoholic solution of gentian-violet to anilin water), 15 m. to 60 m.
5. 1 to 5 minutes in Gram's iodine solution.
6. Decolorize in anilin-oil, two to three hours, or longer.
7. Remove anilin-oil by blotting paper, and mount in Canada balsam.

I have again to acknowledge my indebtedness to the authorities of the Laboratory of the Conjoint Colleges for permission to publish these results of work done there.

ARSENICAL AFFECTIONS OF THE SKIN.

BY JULIANO MOREIRA, M.D.,

Physician to St. Elizabeth Hospital of Bahia (Brazil).

It is a very unfortunate fact attending our therapeutic efforts to cure disease that by the action of the drugs we prescribe we may produce disturbances of various parts of the body, leading to consequences as serious as the original ailment itself. The cutaneous disorders thus produced are not the least interesting of such disturbances. These incidental drug effects constitute a comparatively unexplored field. The physician should be familiar with the skin's changes caused by drugs, because they sometimes may simulate very accurately the rashes of the eruptive fevers, such as measles, scarlatina, r  theln, or more rarely variola, as well as of syphilis, and other cutaneous eruptions due to other causes. It is highly important that the practitioner should always be able, not only to differentiate the clinical features of such eruptions, but to recognize and interpret the pathological significance of clinical appearances so widely dissimilar in their mode of origin.

I do not propose in this paper to study the action of all drugs on the skin which have been accredited with the property of producing eruptive disorders. My sole object is to add various personal observations to our knowledge of the skin affections caused by arsenic, with special reference to the effects of the drug upon the skins of men of coloured race and in a hot climate.

CASE I.—D. E. C., a mulatto schoolmaster, aged 54 years.

Family History.—Unimportant.

Previous History.—The patient is married and father of a healthy son. He has always had good health until the onset of this actual illness. He has never taken alcohol to excess and denies all venereal disease.

Present Condition.—The patient by mistake swallowed a quantity of rat-poison containing arsenious acid, and suffered from acute arsenical poisoning with subsequent multiple neuritis. His wife, his son, and a pupil were also poisoned at the

same time. The first had also subsequent multiple neuritis, but the children had only the symptoms of acute irritant poisoning with arsenical eruption. The patient had severe pains in the stomach, began to vomit and continued to do so for three days at intervals of from six to ten minutes; between the attacks of vomiting he suffered intense nausea and could take no food, while he developed a severe burning thirst. Ten days afterwards he could not walk, and complained of pains in his arms and legs, the latter being particularly sensitive to pressure. When he put his feet to the ground he felt "pins and needles." He could not button his clothes. Thus motor paralysis, sensory trouble and ataxy were present. The knee-jerks were lost. As regards sensation, tactile anæsthesia of the feet was found to extend above the ankle joint. There was marked atrophy of the muscles of the radial, anterior brachial, posterior brachial, anterior tibio-fibular and peroneal regions. Owing to the marked atrophy of the interossei, the lumbricales and the muscles of the thenar and hypothenar regions, the movements of the fingers were greatly impaired. Prolapse of the rectum and obstinate constipation were also present.

History of the Cutaneous Changes.—On March 22nd, 1885, four days after the acute poisoning, the eruption began to appear. He was covered with an universal erythema, which itched very much; the eruption was not raised nor hard to the touch, and disappeared momentarily on pressure; it was most marked on the shoulders, chest and thighs, but less distinct on the hands, face and neck. There were various papules, of the size of a pin's-head, on the fingers and neck.

March 29th.—Eleven days after the occurrence of the acute toxic symptoms, the palms and soles presented a considerable thickening of the epidermis, extending to the extremity of the phalanges, the nails not being involved.

April 2nd.—The face was of a dark brown colour, the skin of the entire body being abnormally pigmented, with a tint comparable to the staining from nitrate of silver. There were dry hard points at the orifices of the sweat-glands. The ankles were œdematous. The appearance of the skin was dirty brown and dingy, as if unwashed, and there was general fine desquamation.

CASE II.—L. K. C., wife of the preceding, aged 43 years.

Family History.—Unimportant. As far as she knows, no instance of any disease like hers ever occurred in the family, which has always been regarded as strong and healthy.

Previous History.—She has always had good health until this actual illness.

Present Condition.—The patient had an attack of acute arsenical poisoning at the same time as her husband. She had severe pains in the stomach, began to vomit, and continued to do so for three days. Food could not be taken, and she developed an intense burning thirst. Twelve days later she could not walk alone and complained of pains in her arms and legs. She could not button her clothes. Thus, motor paralysis, sensory troubles, and ataxy were present. She had no maxillary reflex, while biceps and patellar reflex on both sides was absent. There was marked increase in the salivary secretion. Mastication was very slow and feeble. She could take only soft bread and finely-chopped food. The lips moved sluggishly, and often allowed food to fall out when she was eating. Taste was diminished, salt, sweets and sour not being definitely distinguished. There were little sores on the hard palate, the inner surface of the cheeks, &c. Deglutition was laborious. Prolapse of the rectum and obstinate costiveness were also present. Pulse-rate, 80. Voice monotonous.

History of Cutaneous Changes.—March 23rd, 1895.—Five days after the appearance of the acute symptoms of the poisoning her skin was covered with a rash, followed by countless boils as small as a split-pea. The boils first appeared on the shoulders, arms and back, and subsequently on the legs and forearms.

Ten days after the appearance of the rash a bronzed pigmentation was noted, beginning on the neck, extending to the chest, then to the hands, legs and abdomen. The face and the extremities were swollen. There were hard, dry points at the orifices of the sweat-glands. An intense and diffuse erythema affected the palms and the soles, and was followed in five days by a desquamation of large and thick laminated masses of epidermis.

CASE III.—K. C., a three-year old little boy, son of the previous case.

Previous History.—The patient's general health had always been in every respect quite good, except two slight attacks of intermittent fever, in 1892 and 1893.

History of Skin Eruption.—He was attacked by acute symptoms of arsenical poisoning, in precisely the same manner as his parents. Eight days after the acute poisoning an eruption of discrete pustules was observed.

These lesions, which terminated in crusts or in small ulcerations leaving scars, were noted on the face, shoulders, arms, chest, hypogastrium and right flank. Fifteen days after the acute symptoms I observed a change in the colour of the skin upon various parts of the body. A bronzed appearance showed itself, beginning on the neck, extending to the chest, then to the flanks, hypogastrium and legs, and disappeared, attended by very slight furfuraceous desquamation, in about four weeks; but an irresistible desire to scratch continued for nearly two months. This itching was intermittent, manifesting itself paroxysmally. It was always worse at night. Temperature remained normal.

CASE IV.—C. R. L., a boy, aged 12 years, pupil of Case I.

His *Family History* is unimportant. Father and mother have never had any serious illness.

Previous History.—He had never had any serious previous illness.

History of Cutaneous Affection.—He was affected by the acute irritant symptoms of arsenical poisoning. Six days after the disappearance of these symptoms an eruption of discrete pustules was observed. These lesions, terminating in crusts or small ulcerations leaving scars, were noted on the shoulders, arms, legs and ankles. Boils appeared on the arms and legs.

I was unable to observe any change in the colour of the patient's skin, because he was a black boy; but a very slight furfuraceous desquamation, with an irresistible desire to scratch, occurred and continued for nearly two months. He also had pain in the region of the liver, and two attacks of erysipelas (?) on the legs.

CASE V.—C. J., 20 years of age, with a tawny complexion (father white, mother a mulatto), came to consult me on January 12, 1895, at the Polyclinic of the St. Elizabeth Hospital of Bahia.

His *Family History* was unimportant, except that his father suffered from a severe eczema.

History of Skin Affection.—As he was suffering from an obstinate blepharitis, a physician had prescribed him Fowler's solution. The doses given were as follows: Five drops three times a day for three days; ten drops three times a day for four days; fifteen drops three times a day for fifteen days. Total for the twenty-two days, 840 drops of Fowler's solution.

On the eighteenth day a dry and livid papulo-erythematous eruption appeared on the neck, upper part of the body, arms, hands, legs and soles, with puffiness of the hands and face.

The outbreak was attended by decided itching and lasted some days after the discontinuance of the medicine, followed by furfuraceous desquamation of the parts affected.

There was also slight congestion of the conjunctivæ. The tongue was clean. Pulse, 70; and temperature 38° C. on February 4th. No fever on other days. There was no catarrh.

CASE VI.—C. H., 35 years of age, is a tall, spare man, a commercial traveller.

His *Family History* is good.

Previous History.—He has never taken alcohol to excess, and denies all venereal disease.

History of the Skin Affection.—After an intermittent fever a physician had prescribed for him Fowler's solution. He had taken three-drops doses daily for two months, when a rubeola-like exanthema appeared on the face, neck, and forearms (December 10th, 1894).

When he consulted me, on January 28rd, 1895, I observed the following:—his palms and soles were greatly thickened and indurated. On the dorsal surface of the fingers and hands I noted the appearance of wart-like excrescences. The skin of the limbs was harsh and dry, with faint desquamation. The skin generally had assumed a hyperpigmented appearance.

There was œdema of the eyelids, and slight congestion of the conjunctivæ.

No sign of visceral disease was present, and no albuminuria. The tongue was clean. Pulse 70, and temperature normal. There was no throat redness or glandular enlargement. The skin disturbances disappeared in a very few weeks after the arsenic was discontinued.

CASE VII.—H. C., a tinman, aged 29.

Family History.—Unimportant.

History of the Skin Affection.—As the patient was suffering from pulmonary tuberculosis a physician had prescribed him Boudin's granules.

After taking five granules for six days an *acute bullous eruption* broke out on several parts of the body, beginning on the neck, extending to the thorax, then to the abdomen, shoulders, wrists, hands, legs, and ankles. The blebs varied in size from a split-pea to a goose's egg. Itching was so severe at night as to keep the patient awake, and cause him to scratch himself violently.

CASE VIII.—K. P. G. S., aged 40, a decorator, was admitted into St. Elizabeth Hospital on September 26th, 1898.

Family History.—There was nothing of any etiological importance in his family history.

History of the Skin Disease.—The patient, a habitual drunkard, was suffering from extensive nummular psoriasis, and Fowler's solution was prescribed for him. The eruption was more or less diffused over the posterior aspect of the elbows and the extensor surfaces of the legs.

After taking three-drop doses daily for three weeks, a *soster cervico-sub-clavicularis* appeared on the left side. In the course of a few days the eruption disappeared, but the discomfort remained for some time afterwards in the form of a severe neuralgic pain about the seat of the outbreak. The administration of arsenic was continued.

On November 28th, i.e., three months after the commencement of arsenical treatment, he complained of an affection of the palms and soles. The palm of the left hand showed numerous elevated patches of thick, hard epidermis, from one-eighth to nearly one-fourth of an inch in diameter. They were chiefly encountered upon the palmar aspects of the fingers and along the outer edge of the palm of the hand. The right hand showed a similar condition.

On stopping the administration of arsenic the eruption gradually disappeared.

The patient, who was suffering also from phthisis, died some time afterwards without any fresh eruption having appeared.

The cases I have narrated illustrate, I think, a few of the features of arsenical eruptions.

Several cases of skin disturbances, probably of arsenical origin, were published in this Journal by Drs. Brooke,* Radcliffe-Crocker,† Pringle,‡ &c., but the scattered literature bearing on this subject is not very readily accessible; our readers will find the most convenient source of information in Dr. Prince Morrow's monograph on "Drug Eruptions," edited for the New Sydenham Society by Dr. Colcott Fox; and in Dr. C. Rasch's article, "Contributions à l'étude des Dermatoses d'origine arsénicale," in the *Annales de Dermatologie et de Syphiligraphie*, t. IV., 1893.

In concluding the enumeration of the cases of arsenical eruptions which have been under my personal care, I may state my belief that:—

I. My cases are incontestable examples of skin disturbances produced by arsenic.

II. They prove that arsenical eruptions are not always similar in character.

III. That climate cannot imprint a dissimilarity on the form and degree of severity of the eruption.

IV. That race does not modify, except as to colour, the aspect of the several arsenical outbreaks.

* "Note on some Keratoses of the Palms and Soles," *British Journal of Dermatology*, 1891, page 19.

† "Tylosis Palmæ et Plantæ," *Ibid.*, page 169.

‡ "A Case of Keratosis of the Palms and Soles, probably of Arsenical Origin," *Ibid.*, page 890.

LETTER FROM PARIS.

BY LOUIS WICKHAM, M.D.,

Chef de Clinique at the Saint Louis Hospital.

XVII.

THE PLURALITY OF THE TRICHOPHYTONS.

SIGNOR MIBELLI, Professor of Dermatology in the University of Parma, has recently published a most interesting article in the *Annales de Dermatologie* in which he has repeated, controlled, and thoroughly studied the work which Mons. Sabouraud has been pursuing for several years. He has devoted himself to the study of Ringworm in Italy with great industry, and has now given to the public the results of a great deal of his labour.

His work is divided into two portions, the one scientific, the other practical. In the former, Signor Mibelli states that he recognizes the morbid "entity" described by Mons. Sabouraud as *Ringworm with small Spores*, by the examination of hairs, and by the study of preparations and cultures of the parasite. Signor Mibelli was unable to meet with this form of ringworm, however, in Italy; he could only convince himself of his facts by the study of hairs, specimens and documents sent from Paris, the disease being extremely rare, even if it exists at all, in Italy. This is in strong contrast with what obtains in France, where it is extremely common. Signor Mibelli then identifies four of the forms of Trichophyton which Mons. Sabouraud possesses in his collection, and he identifies and recognizes in these forms the existence of the accidental concomitants of the parasite, which are a grave source of error to those who do not know how to recognize them in works undertaken on the subject.

Thus Signor Mibelli confirms the doctrine of the plurality of the

trichophytons, for which purpose he employed with due control the same technical methods of microscopic examination and cultivation as were recommended by Mons. Sabouraud, as well as the same cultivation media, of the same chemical composition, the same vessels and the same methods of separation of the accidental concomitants.

In the second part of his article, Signor Mibelli states that he does not like the word *Ectothrix* used by Mons. Sabouraud, because the Trichophyton ectothrix presents spores, not only outside the hairs, but also in their interior. Thus the trichophyton with reddish-violet cultivations, which is met with frequently in Italy, although rare in France, presents spores both inside and outside the hairs, so that Signor Mibelli hesitates to classify it among the Ectothrix forms. But it is really an Ectothrix, and Signor Mibelli's hesitation is the result of a misunderstanding, as Mons. Sabouraud has designated under the name of "Ectothrix" varieties which present spores both inside and outside the hairs. Signor Mibelli also regards the division into animal and human ringworm as unfounded, for he believes that a Trichophyton may pass from man to a horse as easily as from a horse to man.

THE THYROID TREATMENT OF PSORIASIS.

It will be of interest for the readers of the *British Journal of Dermatology* to learn the recent work done in France in control of the researches of Dr. Byrom Bramwell, published in the *Journal* on the subject of the Treatment of Psoriasis by the Ingestion of Thyroid Gland. Dr. Thibierge recently made an important contribution on the subject to the Congress held at Bordeaux, which may be thus briefly epitomized.

The experiments were made upon eleven men affected with typical psoriasis of the common form. In all instances the thyroid gland itself was administered, fresh and uncooked, cut into thin slices, and given in a warm broth; this practice gives every assurance of the freshness of the remedy, and of its authenticity. The glands were carefully weighed every day, and the weight noted; they were usually taken from sheep, but occasionally from calves. During the treatment, the patients received no other medication, either internal or external. Its duration lasted from eighteen to fifty-four days. The

total doses varied from 72 to 288 grammes for each patient ; the daily dose varied from two to seven grammes, in exceptional cases rising to 11, 12, 16, and even 20 grammes.

The effects produced by the treatment on the different organs of the body were as follows :—

1. *Pulse Rate*, varied from 100 to 110 per minute, but the pulse remained full and regular. No palpitation was complained of.

2. *Temperature* remained normal throughout.

3. *Headache* was occasional — generally frontal and of slight intensity ; there were slight articular pains.

4. *Digestion* was almost invariably disturbed ; gastric catarrh of varying intensity generally set in on the fifth or sixth day of treatment.

5. *Appetite* varied ; at first it was always diminished, but towards the middle of the treatment it became a real boulimia, which disappeared on the cessation of the treatment.

6. *General Nutrition* always suffered. There was invariably sensation of lassitude, rheumatic pains, general pallor, loss of flesh ; all the patients lost from two to nine kilogrammes. Weight was soon regained after stoppage of the treatment.

7. *Urine* was always increased in quantity from 2,000 to 3,000, or even 4,000 grammes daily.

What were then the results produced by the treatment ?

In three patients there was no alteration whatever—the results being *nil*. In the remaining eight there was a manifest improvement, which showed itself by a diminution in the extent and intensity of the redness, in the size, thickness, and colour of the scales, which became reduced, the large patches seeming to break up into a large number of small papular elements, more or less isolated, each covered with a small independent squame. Some disappeared, the seat of the former lesions being only indicated by a reddish-brown or brown spot, which gradually faded until the skin resumed its normal colour. This regression of the lesions only took place in a few of the psoriatic patches, and none of these eight cases could be considered as cured, despite the long duration of the treatment. From these researches, Mons. Thibierge concludes that the thyroid treatment does not deserve the title of a specific for psoriasis, that it fails, indeed, in the cure of that affection, and that it ought only to

be tried where other methods of treatment have failed to bring about a good result.

In two cases in which I tried thyroid treatment my patients rapidly lost flesh, and their skin affection was nevertheless completely unaltered.

**DERMATITIS HERPETIFORMIS CONSIDERED AS AN AUTO-INTOXICATION
DUE TO RENAL INADEQUACY.**

As the result of recent experiments and observations at Saint Louis Hospital, there is a wave of opinion in favour of the renal pathology of Duhring's Dermatitis herpetiformis. Mons. Gaston has made two autopsies of cases of the disease, and in both he found renal sclerosis. Messrs. Leredde, Perrin, and myself have established the existence almost constantly of a diminution of nitrogen in the urine (hyposaturia). Mons. Perrin has established, by experiments on mice, the diminished toxic properties of the urine, and at the same time the markedly toxic properties of the liquid contained in the bullæ. Finally, Mons. Leredde has discovered the presence in very large numbers in the liquid of the blebs and in the blood of the patients of eosinophile cells (*i.e.*, of leucocytes which contain a fixed acidophile substance), whereas in normal conditions they are very rare.

Putting together these facts, Leredde concludes that a toxic substance which is eliminated in health in the urine, is no longer eliminated owing to renal disease; that this toxic substance acts on the one hand on the nervous system, causing the nervous troubles of the disease; on the other hand, it is present in the blood and in the liquid of the bullæ, thus determining the eruption; and, finally, that it is this very substance which is fixed in the leucocytes—in their numerous eosinophile cells.

This theory fits in well with the fact that the affection coincides so frequently with pregnancy (which is so often accompanied by diverse auto-intoxications resulting from renal inadequacy), and with the fact that the death of the foetus so frequently occurs in *Hydroa gravidarum*.

In the treatment of the disease it is therefore necessary to pay particular attention to the kidneys and to further renal elimination, especially by giving abundance of milk.

LOCAL ANÆSTHESIA IN MINOR DERMATOLOGICAL OPERATIONS.

Some months ago Mons. Dubreuilh, of Bordeaux, recommended intradermic injection of hydrochlorate of cocaine as the best local anæsthetic. In a recent work on the treatment of Lupus, Mons. Foubard has taken up this matter afresh, and we have ourselves made some experiments on the subject.

It is certain that the local anæsthetics now usually employed at Saint Louis do not satisfy all the conditions. The *Chloride of Methyl*, which is principally used, hardens the tissues and changes their colour by freezing them, so can seldom be employed for operations on lupus, for instance; one must therefore often operate with an anæsthetic.

The objection to the *Chloride of Ethyl* is that it sometimes takes fire at a touch of the thermocautery, and therefore cannot be used for cauterizations.

The *Hydrochlorate of Cocaine* has for a long time past been used from time to time at Saint Louis for the removal of small tumours, for small pieces of lupus verrucosus, &c.; but Mons. Dubreuilh has, as it were, systematized the employment of cocaine, and since the publication of his work it is used in the majority of the services with certain modifications of dose and of the method of application.

The following rules, recommended by Mons. Foubard, are excellent:—A one *per cent.* solution is sufficient for all purposes; but if it is intended to anæsthetize a large area of the skin, a solution of one gramme of hydrochlorate of cocaine in 200 grammes of sterilized water is even more serviceable. It does not produce total loss of sensation, but the pain is very slight, and with it one may quite sufficiently anæsthetize surfaces ten centimètres square.

Ten to twelve or fifteen centigrammes is the maximum dose to be employed when using the one *per cent.* solution. But in reality it is difficult to measure exactly the quantity of liquid injected, for a certain number of drops always ooze out after each injection.

The injection must be carefully made into the skin by slowly inserting the needle while pressing the piston, and by thus establishing anæsthesia in front of the point, it can be inserted pretty deeply. A patch to be operated upon may thus be circumscribed or crossed by injections. When several injections are made care is taken never to

insert the needle at spots already anæsthetized by previous injections. By following these rules and adopting the dosage indicated there are no dangers to be feared.

Although we accept the greater number of rules laid down by Mons. Dubreuilh, we do not go so far as he in employing the method for all dermatological operations. In our opinion cocaine should be employed only where it is advantageous to see what one is doing, and therefore to preserve the colour and consistence of the tissues, *e.g.*, for cauterization and scarification in Lupus erythematosus, Lupus vulgaris, &c.

We think, on the contrary, that there is some advantage in certain cases in hardening the tissues, as, for instance, for scraping a Rodent ulcer, where it is better to remove too much tissue rather than too little. In such cases, as in certain forms of tubercular ulceration, I do not use the chloride of methyl, but the chloride of ethyl, which, contained in tubes with a capillary extremity, is very handy to use. An assistant, holding the tube in his hand to heat it, projects the little stream of liquid from it on to the part to be operated upon. As soon as the freezing is accomplished the scraping is boldly done, and is favoured by the firm consistence obtained by the freezing. As the dangers to the patient from cocaine—which are admittedly rare—are thus avoided, the chloride of ethyl offers in these cases certain advantages.

SOCIETY INTELLIGENCE.

DERMATOLOGICAL SOCIETY OF LONDON.

AN Ordinary Meeting of the Society was held on Wednesday, November 13, 1895.

Dr. COLCOTT Fox presented (1) a woman, aged 54 years, suffering from *Onychia of all the fingers and toes*. The affection began eleven weeks previously in the little finger, and then the thumb of the left hand, the other fingers of the same hand and the corresponding parts of the right hand quickly followed suit. The toes of both feet were involved about the same time, but the patient did not remember the exact sequence. On presentation the ungual phalanges on all surfaces were reddened, swollen, hot and painful, and evidently the seat of a chronic inflammation. The nails were either shed or in process of separation, but were in themselves little altered in texture. There was no trace of suppuration. It was the first attack of the kind experienced.

The exhibitor said he had great difficulty in assigning a cause for this condition of onychia, using the word in the widest sense. There was no clue to any syphilitic infection, nor could he ascribe it to any condition to which the name "scrofula" could be applied. The woman seemed to be in good health. It was unlike the cases of septic origin, nor could he account for it by any local irritant. The woman went out washing a great deal, but never worked with bare feet in a laundry. The exhibitor occasionally saw barmaids and potmen with a somewhat similar affection, limited to the hands, which were constantly bathed in beer. Lastly, he had sought for symptoms of nerve disorder, but he could not detect any evidence of spinal or peripheral trouble. The patient did, however, complain that the arms "went dead" at night.

Dr. COLCOTT Fox exhibited (2) a man, aged 28, with a band of *Sclerodermia* of a yellowish tint, extending down the inner part of the lower third of the left thigh, past the knee-joint, and on to the leg on

the inner side. The skin could not be pinched up, and appeared to be bound down to the underlying structures. The band was of three months' duration, and caused no inconvenience. There was no apparent cause. It was suggested that its localization corresponded to some extent with the territory of the internal saphenous nerve.

Dr. JAMES GALLOWAY brought forward (1) a case of *Maculo-anæsthetic Leprosy*. The patient, a young man of 23 years of age, was a native of Barbadoes, and was partly of negro extraction. He had been well educated, had acted as classical teacher in some of the colleges in the British West Indies, and had lived in Nevis and in Demerara as well as in Barbadoes. While in the latter island he had come much in contact with persons suffering from leprosy, and was inclined to date the onset of his disease from that time. During 1894 he had noticed that he suffered from great lassitude, but had not observed any attacks of fever nor the occurrence of undue sweating. The debility he put down to residence in the warm atmosphere of Demerara. In February, 1895, he noticed that the hands and feet commenced to swell, and that dark spots appeared on the skin, the first one observed being on the right forearm. Recognizing what had befallen him, he decided to come to England. At present the patient has numerous pigmented areas scattered over the body, which are most numerous on the trunk. A few of the older spots are now, however, less pigmented than the surrounding skin; for example, the spot already mentioned on the right forearm. All the spots are distinctly anæsthetic, though the degree of anæsthesia varies, and does not appear to be absolute in any of them. The ulnar and external popliteal nerves are readily felt to be much thickened, and there is a considerable degree of œdema of both extremities. In the hand a slight degree of loss of power can be noticed, with atrophy of muscles. No nodules or tubercles can be observed on the skin.

The mucous membranes are, to some extent, affected. At one time he used to sing a good deal in public, but has been obliged to desist from this, as his voice has altered in quality, but no distinct thickening can be observed in the neighbourhood of the vocal cords. The nasal mucous membrane is a good deal thickened, so that there is considerable difficulty experienced in breathing through the nostrils. On examination the membrane is much thickened, and any

attempt to pass a nasal bougie for the purposes of dilatation is attended with excoriation.

His general health up to the present has shown no serious deterioration.

(2) A case of *Elephantiasis of both lower extremities*. The patient was a woman of 47 years of age. She was born in Italy, but had lived in England since the age of 2½ years. She had married in England, and had several children. The present condition showed itself about three and a half years ago, one year after the birth of her last child. The swelling had gradually increased, and had been accompanied by attacks of painful erythema and ulceration of a superficial character in the neighbourhood of the knees. The œdema had now become stationary and the ulceration had ceased, although the skin over and surrounding the knee-joint was thickly covered with soft, pliable, non-adherent scars. At the instep there were masses of warty growths, which were increasing in extent and seriously impeding locomotion. The condition of the limbs was quite obvious, and the exhibitor inquired, What was the probable cause of the elephantiasis?

It was considered that the scars described were of syphilitic origin, and that as there was no other cause for the elephantiasis discernible, that the syphilitic inflammation had given rise to lymphatic obstruction, and in this way the elephantoid condition had resulted.

Mr. J. HUTCHINSON, JUNIOR, showed a good example of the *corymbose Syphilide*. The patient was a middle-aged man, who contracted syphilis eight months before exhibition. He had been very imperfectly treated until two or three weeks ago. He now presented a copious lichenoid syphilide of a vivid reddish-brown colour. The grouping was quite peculiar, especially on the back. There was in the centre of each group a large brown papule (lenticular), with a great number of smaller ones around, in some cases upwards of a hundred. There were in all about a dozen of these patches—varying in size, but each presenting the same arrangement.

The general opinion of members was that it was a very rare form of syphilide, but exactly resembling a wax model in the Royal College of Surgeons, copied from one of Baretta's in the museum of the Saint Louis Hospital.

Dr. PERRY exhibited a case of *Hyperidrosis, with a peculiar form of plantar Tylosis*. H—, a male, æt. 17, was sent to see the exhibitor for a cutaneous affection of the feet.

He was a dark-haired, healthy-looking youth, who had never had any severe illness, and had never suffered from any skin disease before the present attack. He states that his hands and feet are always sweaty and cold, and that he often lies awake at nights for hours with cold feet; that, when the cold feeling passes off, they became most uncomfortably hot, and latterly extremely irritable. The affection of the feet began in the hot weather last May, the right foot being attacked a little earlier than the left. The initial lesion is described as being like "a blister," but on further inquiry it is stated to have resembled the small patch close to the external malleolus described below. The patient has never suffered from chilblains or rheumatism.

On inspection his hands are noticed to be blue, and cold to the touch, but otherwise normal; his feet are pale, moist and fairly warm. The skin of the soles is thickened generally, and sodden, the thickening extending to form a sort of heel-cap, with a well-defined red border. Besides the general thickening there is on either foot an oval dull-red patch situated on the inner side over the internal cuneiform and base of the first metatarsal bones, the patch on the left foot, which is slightly the larger, measuring an inch in its longest diameter. The skin over the affected part is thicker than normal, roughened, and warty-looking, with a narrow red border which fades into the pale skin surrounding it. At a short distance from the patches are seen several flattish papules, varying from a line to an eighth of an inch in diameter, and resembling a papular erythema. Another oval patch, about a third of an inch in length, is seen just below the right external malleolus in a situation not exposed to the pressure of the boot. This lesion differs from the larger ones in that the skin shows no thickening, and the patient says that the larger patches began like this one, which is indistinguishable in character from an erythema multiforme.

The case appeared to the exhibitor to form a connecting link between the ordinary form of tylosis associated with hyperidrosis, and the erythema keratodes described by Brooke in the *Journal of Dermatology*, 1891, p. 385.

Mr. MALCOLM MORRIS showed (1) a case of *Lichen planus*, associated with *Keratosis pilaris*, in a female, aged 64. The disease developed eighteen years ago as small, purple, highly irritating papules. Since that date the disease had slowly increased, but during the last three months the irritation is said to have greatly diminished. When she first came under observation the diseased process was associated with hair follicles constituting a *Keratosis pilaris*, but since then the follicular lesions have increased in size and coalesced so as to form agglomerate rough patches of violet tint in the centre and of warty appearance at the edge. The patches are situate on the anterior aspect of the legs, two inches and a half below the tubercle of the tibia.

(2.) A boy, aged 16, son of (1), and presenting an almost identical condition, of twelve months' duration. The papules were for the most part connected with hair-follicles, but a few had apparently no such connection, and were characteristic, flat-topped, shiny planus papules. Latterly the appearances have altered, owing to complications from pus inoculation due to scratching.

(3.) A case of *Lupus vulgaris* under thyroid Treatment for the last nineteen months. The patient was a man aged 23, in whom the disease commenced at the age of 5½ years. It had caused most extensive destruction of the tissues of the nose, cheeks and neck. Thyroid treatment was begun in April, 1894, and had been continuously pursued ever since, the patient taking from one to five tabloids daily. The only local application has been a weak antiseptic ointment. At the time when the treatment was adopted the disease was making rapid progress, but since that time all ulcerations have healed, and the disease has steadily progressed. At first the patient did not stand the remedy well, the pulse rate being considerably accelerated and the appetite failing; he had also rise of temperature. But latterly his general health is not at all affected by the remedy.

Mr. MALCOLM MORRIS also brought forward (4) a woman, aged 44, suffering from extensive and extremely rapidly spreading *Cancer en Cuirasse*, which began four months ago with hardness in the skin of the breast above the right nipple. The induration rapidly spread towards the right axilla, and the glands became enlarged. During the last six weeks the disease has spread over the chest, across the left breast, and down the abdomen.

(5.) A case for *Diagnosis* in the person of a young woman, aged 27, who presented symmetrical circular patches of disease on the extensor surface of both forearms and similar lesions on the upper part of the right thigh, in the left flank, and in the præsternal region. The disease first showed itself at the age of 4 years, and had been continuously present, the patches which were roughly circular in outline, with a raised squamous margin spreading centrifugally, while the centre became converted into thin atrophic scars without the occurrence of ulceration.

The case had been diagnosed as Psoriasis by a distinguished German dermatologist, but this view was not generally accepted. Opinions upon it were greatly divided, some members thinking it an atrophic Lichen planus, others a form of Lupus erythematosus. The exhibitor's view was that it was a very superficial form of *Lupus vulgaris*.

(6.) Two young children of the same family, with an immense number of *Comedones* inside the ears, the other common seats of comedones in children being totally unaffected.

Dr. RADCLIFFE-CROCKER brought forward a case of *Whitlows persistent for thirty-five years*. A woman, æt. 51, had suffered from whitlows on her right index finger and left thumb for thirty-five years. The first had appeared on her right middle finger, but all the others had been confined to the digits above-mentioned; she was scarcely ever quite free; the longest interval she remembers is two months. The whitlows were painful; there was moderate deformity of the terminal phalanges. There were no joint lesions or sensory disturbance of any kind, and in the total absence of all corroborative symptoms the exhibitor did not feel justified in diagnosing Morvan's disease, but thought that the whitlows might be accounted for on the supposition of persistent pus-cocci infection, and hoped to effect a cure by removing the nails and thoroughly disinfecting the tissues.

(2.) A man, æt. 21, with *persistent exfoliative Dermatitis*, limited to the lower limbs, extending from the groins to the dorsum of the feet. There was a bright red surface, with large flaky exfoliations, the flakes being rather thick, due to an admixture of dried exudation with the scales. Since he had been in University College Hospital (about a month) he had two crops of flat and flaccid bullæ, containing sero-pus

resembling those of *Pemphigus foliaceus*. In the first attack there was a rise of temperature to 102° F., but there was no such disturbance in the second attack. No reliable description of previous attacks could be obtained from the patient, who was an Irishman with a defective intellect. The exhibitor asked the members if the case was to be regarded as a localized *Pemphigus foliaceus*, and several members were inclined to adopt that view.

(8.) A boy, æt. 12, who had a slight recurrence of *epidemic exfoliative Dermatitis*. The boy lived in a large cottage on a hill in the country, and had had a previous severe attack of what the family doctor called "acute exfoliative dermatitis." The father, mother, and three other children had been affected. The source of infection was not traced. Further details will be published subsequently.

THE DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND
IRELAND.

AN Ordinary Meeting of this Society was held on October 23rd, 1895, Dr. P. H. PYE-SMITH, F.R.S., President, in the chair.

Mr. EDWARD COTTERELL exhibited a case of *Lupus erythematosus* associated with a *tubercular Dermato-syphilide*. The patient—a female—contracted syphilis three years previously. Four months ago typical *Lupus erythematosus* of the nose and cheeks existed together with several distinct tubercles of *dermato-syphilis*. The *lupus* practically disappeared under resorcin locally applied together with internal tonic remedies. Anti-syphilitic treatment is now causing rapid disappearance of the tubercles.

Mr. LEONARD BIDWELL showed a case of *Lymphangioma* on the front of the left knee of a woman aged 51 years. Fourteen years ago a similar swelling over the knee was noticed, which was removed by excision four years later. She remained quite free until a year ago, when a fresh development occurred of a similar kind, together with thickening of the subcutaneous tissue, the whole being tender to the touch. Removal by operation was intended.

Dr. P. S. ABRAHAM showed the following cases :—(1) *Pemphigus* in a girl who had been practically covered with bullæ. It commenced as erythematous rings, which gradually spread until the affection became nearly universal over the body, but the face was involved in a lesser degree. Itching was slight. The rings were now disappearing. The family history was unimportant.

(2) *Lupus Erythematosus* of sebaceous type in a girl aged 14 years. The cheeks, nose and forehead were involved. There was much acne upon the forehead and chin, and in addition, some eczema on the chest, arms, and behind the ears, together with desquamation of the scalp. The disease originated at the early age of nine years. An elder brother died of phthisis, but the other members of the family were healthy.

(3) *Dermatitis herpetiformis* in a man to contrast with *Pemphigus* (Case I.). The patient had much improved since he was shown in April last, although the erythema remained, besides a tendency to the formation of bullæ on erythematous bases. Severe itching was a prominent feature, for which tar applications were given, and the arsenical treatment was continued. The skin on the palms of the hands and soles of the feet was thin and glossy, and the leg resembled a published illustration of *Dermatitis herpetiformis*. When first seen the back was covered with excoriated and hæmorrhagic papules. The erythema showed a tendency to group.

Dr. PAYNE, who had previously seen the case, confirmed the diagnosis, and said it was sometimes difficult to differentiate between *Dermatitis herpetiformis* and *Pemphigus*.

(4) A man aged 77 years, who consulted him two months previously for a painful swelling on the side, characterized by a fungating mass of tissue, which protruded through the epidermis, and by its appearance suggested malignancy. Itching was complained of. A papular eruption appeared on one arm and sebaceous warts on the back. He admitted the possibility that the growth was an inflamed and ulcerating sebaceous wart, which had been exposed to much friction and irritation. Tar baths and an ointment of mercury, and ichthyol with general tonics, had produced considerable improvement.

Dr. RADCLIFFE-CROCKER said that, in his opinion, the growth was not an epithelioma.

Dr. ABRAHAM added that when the patient first came to him there was a mass protruding to the extent of a third of an inch with soft granulations. At one time he suspected Mycosis fungoides. He at first intended to excise the growth, but the protuberances were now disappearing.

Dr. ABRAHAM also exhibited (5) a private patient, a female, aged 19 years, as an example of *Leprosy*. She was born in Ceylon of English parents, and came to England twelve years ago. In 1890 she had what was thought to be acute rheumatism, in the course of which spots and erythematous blotches appeared. She consulted several dermatologists in London, the general opinion being that she was suffering from Erythema nodosum, but one member of the Society present at the meeting had correctly diagnosed the affection. Now the discoloration was principally on the face and legs, but there was no ulceration. From time to time fresh patches developed. The anæsthesia was very slight indeed. Photographs taken six months ago were exhibited to show the amount of improvement which had taken place. It was well known that temporary improvement in this terrible disease often roused spurious hopes of recovery which were not realized. The patient had been treated with gynocardate of magnesia in pills (three grains three times a day) and arsenic, and iron with meals. The former drug seemed equal in its effects to chaulmoogra oil, and was less liable to disagree. Creolin baths were also prescribed, and in addition inunctions with chaulmoogra oil, vaseline, and 1 per cent. of Europhen. He had strongly urged that the ointment should be systematically and continuously applied. Any new lesion was to be vigorously treated at once in this way. Several recorded cases proved that this treatment had been efficacious in retarding relapses, in one case for a period of five or six years. Dr. Abraham referred to a recent paragraph in a newspaper relative to an alleged cure of leprosy by inoculation with erysipelas. The announcement of Dr. Impey, of New South Wales, was not new. In a case in which such inoculation was performed in Mexico the practitioner in charge was so scared by the result that he resolved not to attempt it again.

Dr. CROCKER said he was glad of an opportunity of seeing the patient again. Five years ago, when the disease was only of three months' duration, the patient was brought to him for a

confirmatory opinion, and he had not seen her since. An interesting feature was that the symptoms did not appear until at least five years after arrival in England, proving how difficult it was to trace the origin of the disease. She had what was regarded as rheumatic fever, followed by red prominences on the forehead, and other parts of the face, but otherwise seemed a fair, healthy English girl. On the arms the spots had been diagnosed as Erythema nodosum. A raised erythematous ring was visible on the arm, followed by red nodules, but there was no marked anæsthesia anywhere. There could be no question as to the diagnosis even then. Dr. Crocker agreed with Dr. Abraham as to the treatment, but he considered it unimportant what kind of fat was used for inunction supporting his view by quoting a case in which a medicated ointment, was used on one side of the body, and olive oil on the other simultaneously, the latter appearing to have produced more benefit. The President, and Dr. Abraham, referred to cases of leprosy in their experience in which the outset had commenced several years after the patients had left tropical countries.

Mr. A. SHILLITOE exhibited a case of extensive *rupial Ulceration*. The patient, a young man, acquired syphilis last May, and was admitted during August into the Lock Hospital in a very emaciated condition, with extensive rupial ulceration on the head, face, shoulders, arms and legs. On September 24th a mixture containing the iodides of soda and potash was prescribed, which produced much improvement, but an unusual subcutaneous hæmorrhage occurred around the semi-healed ulcers about a fortnight afterwards. The history of the case suggested a tendency to hæmophilia. The patient was still improving, the same treatment being continued.

Dr. ALFRED EDDOWES showed the following cases:—(1) *Xeroderma* in a girl aged 11 years. She had taken one tabloid of thyroid extract daily for several months, now increased to two. Vaseline had been applied externally as a placebo. The improvement which had occurred, both generally and locally, he considered the direct consequence of treatment.

Dr. CROCKER remarked that the effect of vaseline was more than a placebo in such a case.

Dr. EDDOWES replied that the great improvement in general health could not have been produced by the inunction.

Dr. ABRAHAM stated that he had frequently used thyroid extract in such cases, but always supplemented it with tar ointment, and tar baths. He was of opinion that thyroid extract was more useful in xeroderma than in psoriasis.

Dr. EDDOWES said he had had other cases which distinctly benefited from thyroid extract, but less markedly than in the case he had exhibited.

(2) *Ichthyosis hystrix* in a girl aged 19 years, of congenital origin. Both hands were affected, and the feet slightly so. The nail of the third finger of the left hand was thin, brittle, and vertically ribbed. On the inside of the little finger, the part most involved, he had applied the actual cautery, which produced a scar. Other parts he had painted with the acid nitrate of mercury solution, but it was not so satisfactory as the actual cautery. He possessed a drawing of a case in which the disease extended in a linear form down the leg, and round the ankle, and re-appeared at the base of the small toe.

(3) *Lichen planus*.—A woman, aged 30 years, presented a patch of lichen of one year's duration in front, and below the knee. Around the original patch were scattered several new satellites, but these in no way resembled the lesions seen in a case of Angio-keratosis which he had previously exhibited, and which he believed some of the members held to be lichen.

(4) *Sycosis Menti*.—The patient, a young man, was recovering from the affection which had existed five years previous to Dr. Eddowes seeing him. Under the present treatment, now of several months' duration, recovery was almost complete. The fungus of tinea could not be traced, and hence he suspected micrococci as the cause.

(5) *Chronic Folliculitis* (Sycosis) of the whole of the upper lip, with much thickening, of ten years' duration. Dr. EDDOWES considered that the disease was produced and aggravated by a chronic nasal catarrh. A photograph was exhibited proving the severity of the case previous to treatment.

Dr. STOWERS exhibited a male patient with well-marked *Tinea Barbae*, contracted whilst being shaved, the fungus having been demonstrated. The region of the beard showed extensive and

acute folliculitis. When first seen there was considerable secondary glandular enlargement. Treatment, which consisted of epilation and mild mercurial ointment, followed by the use of the oleate of mercury, 10 per cent., had been continued for a fortnight with considerable improvement. Dr. Stowers suggested that such cases were frequently overlooked and strongly advocated the use of the microscope for diagnostic purposes. The hairs required to be well cleansed with ether, and soaked for many hours in liquor potassæ.

MICROSCOPIC SECTIONS were exhibited by:—Dr. ABRAHAM and Mr. BIDWELL conjointly: (1) Rodent Ulcer; Dr. STOWERS: (1) Rodent Ulcer; (2) Molluscum Fibrosum.

FIFTH CONGRESS OF THE GERMAN DERMATOLOGICAL SOCIETY.

THE subject chosen for debate on the second day was *The Influence of early Mercurial Treatment of Syphilis in preventing Tertiary Manifestations*. The conclusions formulated by Professor CASPARY, of Königsberg, were :—

(1.) Statistics have not shown definitely that Fournier's "chronic intermittent" method of treatment protects any better from tertiary symptoms than other methods. (2.) Persistent and energetic dosage with mercury is accompanied by unjustifiable risks. (3.) The reporter practises and recommends so-called "symptomatic" treatment in mild secondary forms. If some secondary manifestations or tertiary symptoms develop, he always endeavours to carry out a course of treatment after Fournier's method, provided there is no contraindication for it.

Professor NEISSER, of Breslau, in an elaborate and able paper, expressed the following views :—

(1.) Tertiary manifestations of syphilis, just like the papular lesions of the early period, are produced by an organized virus (syphilis bacteria); but the virulence of these bacteria is so modified—at least in the later years of the disease—that they are not infective for healthy individuals, and they are only capable of acting and of causing new formations in an organism already saturated with them.

(2.) The following points must be borne in mind in considering the ætiology of the tertiary symptoms.

(a.) The special causes of any given tertiary process, *i.e.*, the causes of its localization; such are (1) remains of the virus in the seat of the primary or preceding secondary lesions; (2) accidental provocation of the virus from trauma or pathological processes.

(b.) The general causes which favour the persistence of the virus in the body, *e.g.*, alcohol, marasmus, malaria, etc., which diminish the power of resistance of the organism, but especially the insufficient, or too late administration of mercury.

(3.) The real and most potent ætiological factor in the production of tertiary symptoms is the lack of proper mercurial treatment in the early period.

The following are the points to bear in mind in a properly conducted mercurial treatment:—(1) it must be instituted early, and indeed begun with the first manifestations, as soon as the diagnosis is certain; (2) it must, in the first instance, be applied with great energy; (3) it must be carried out for a long time, generally for more than three years, in alternating energetic and mild courses of treatment, separated by sufficient intervals.

The method of administration of the drug is of secondary importance. The selection of the method will depend upon (1) the special object of the course of treatment, whether it is to be rapid or slow, of long or of short duration, and the case severe or mild; (2) the external conditions under which the treatment is carried out; (3) the special properties of each preparation of mercury employed, its capability of absorption, &c.; (4) individual idiosyncrasies of patients.

(4.) Mercury alone is to be regarded as the sole remedy which attacks the syphilitic virus itself; in proof of which is its effect upon the capacity for begetting children. Preparations of iodine have only the power of influencing syphilitic products, and almost exclusively those of the tertiary period. Bath and sweat "cures" are often useful in supporting the action of mercury, but they have no direct anti-syphilitic action. In spite of its theoretical propriety, serum treatment has been followed by no definite results.

(5) Appropriate mercurial treatment, intelligently conducted and suitable to the circumstances of the individual, is absolutely harmless.

(6.) It is an error to consider the frequency or form of the earliest manifestations as the sole standard for the sort and number of mercurial treatments (1) if, on the one hand, much mercury is given without sufficiently long pauses in frequently recurring relapses; (2) on the other hand, we know that the absence of early manifestations gives no information as to the prognosis of the later phases of the disease. Therefore one must endeavour to cure every patient of his chronic disease by a chronic course of treatment, exception being made for a few special cases.

(7.) The enormously frequent occurrence of tertiary syphilis in cases left untreated, or inadequately treated, with mercury is a proof of the ætiological relationship claimed. This we know from the formerly described epidemics of syphilis (Radeszyge, Skerlievo, &c.) and from recent Russian literature.

Moreover, all cases of *Syphilis hereditaria tardiva* belong to this category.

(8.) Our own tertiary material shows a strikingly large percentage of syphilis, treated either badly or not at all, in the early stages; all allowance being made for unreliability of statistics and history, and even for the dubious connection between syphilis and many conditions referred to it (tabes, paralysis, many leucoplakias, &c.).

(9.) The fact that very frequently regions which are the seat of primary and secondary lesions afterwards present tertiary manifestations indicates that the local treatment of the early eruptions is of great importance in warding off tertiary relapses.

(10.) Particular attention should be paid to the local treatment of enlarged lymphatic glands, in consideration of the fact that they may be the seat of virus remaining latent in the system.

(11.) It is uncertain whether the early appearance of tertiary symptoms—*Syphilis præcox*—is accompanied by early cessation of the period of infectivity and early return of the capacity of begetting children.

(12.) "Malignant" syphilis is not to be considered a form of tertiary syphilis.

The ensuing discussion was lengthy and vigorous, but no new points were brought forward, and probably no opinions were changed. Those who took part in it were Pick, Jarisch, Jadassohn (who brought

forward very elaborate statistics in favour of Neisser's eighth point), Glück, Havas, Barlow, Finger, Peterson, Petrini, Touton, Herxheimer, Mraček, Philipsson, Perić, Schwimmer, and Kaposi.

Among other papers of special interest was one by Prof. PETERSON (St. Petersburg) on *Trichorrhexis Nodosa*. He said that the disease, although little studied, was in reality a very common one, especially in Turkey. In Russia he had frequently seen several cases in the same family. It is far commonest in people who have their hair cut at long intervals. He was unable to confirm Raymond's statement that the disease is of frequent occurrence in the pubic hairs of *puellæ publicæ*. The nutritional disturbance of the hairs is due to a variety of causes, among others, to different micro-organisms.

Dr. SPIGLER (Vienna) said the disease was very common in Vienna, especially in the moustache; the same micro-organism is always present, which is probably identical with that discovered by Hodara in the hair of Turkish women, but cultures are sometimes difficult to obtain. In treatment shaving is of little use, as the bacillus penetrates into the subepidermal portion of the hair. Dr. BARLOW (Munich) had investigated one case by Hodara's method, but without result. Dr. VEIEL (Cannstadt) had cured two cases with pyrogallol in a 2 per cent watery solution after epilation. Dr. JADASSOHN had also cured a case with a 2 per cent. pyrogallol ointment.

Dr. KRÖSUNG (Stettin) contributed a long and contentious paper upon the *Trichophyton* fungus, in which he combated many of the earlier statements of Sabouraud without reference, however, to recent literature. He denied even the accuracy of Sabouraud's first subdivision of the Ringworm-producing fungi into large and small spored varieties, basing his conclusions on culture experiments. The microscopic differentiation of various cultures is impossible owing to the various forms of organs of generation and fructification in the same culture, and their various modifications in various circumstances. Only the naked eye characters of cultures permit of a differentiation of various species, and cultures on potato are the most characteristic and most suitable for comparison. By them three principal forms may be distinguished (a) those which form a dry powdery layer with brown discoloration of the potato round the margin of the culture; (b) similar, but without a change of colour of the potato; (c) those which form a white woolly layer without discoloration of the potato. He further contended that the superficial and deep forms (Sycosis and *Tinea circinata*) may be due to the same fungus; that there are suppurative diseases due solely to *Trichophyton*; and that it is impossible on clinical grounds to predict the form of fungus to be found. His inoculation experiments on animals were negative.

Dr. ULLMANN (Vienna) followed with a paper on the same subject, referring to ten cases of so-called Herpes tonsurans corporis, in which he could find no specific micro-organisms.

Dr. JADASSOHN (Breslau) and Dr. PRINGLE (London), who discussed the papers, identified Dr. Ullmann's cases from photographs shown as typical examples of the Pityriasis rosea of Gibert, and referred to recent harmonizing writings of Mibelli, Sabouraud, and Adamson on the subject of true Ringworm.

Dr. TOUTON (Wiesbaden) read a capital paper on the *Neurodermitis circumscripta chronica* (Brocq), or *Lichen simplex chronicus circumscriptus* (Cazenave-

Vidal), which he regards as neither a chronic Eczema nor as a Lichen, but as a local Pruritus, with consecutive thickening of the skin, and, as such, closely connected with Hebra's Prurigo. The supervention of other effects of scratching, of dermatitis, and especially of pus infection (impetigo, boils) is not essential, and does not justify a differentiation between a "simple" and a "polymorphous" form. It is of equally little importance whether or not the disease shows itself in one or more regions of the body at one or at different times, or whether it spreads over the greater portion of the body (so-called Eczema pruriginosum, Prurigo of adults, Pruritus universalis). There are cases which are localized in Voigt's lines of fission of the skin in the terminal distribution of cutaneous nerves.

Dr. VEIEL (Cannstadt) contributed a paper on the *Therapeutic Value of Aiol*, which is a combination of Bismuth, Gallic acid, and Iodine. It is insoluble in water; but under its influence ulcers clean rapidly, become painless, and secretion diminishes. It is specially valuable under a zinc glyco-gelatine dressing, as it causes no dermatitis and can be employed where there is a good deal of eczema. He also recommended its use in in-growing nails, and in Dermatitis repens; while a 100 per cent. salve is valuable in Sycosis and Lupus. In soft chancres iodoform is better.

Dr. JUSTUS (Buda-Pesth) gave an interesting demonstration, illustrated by the lime-light lantern, of the lethal effect of syphilis on the coloured blood corpuscles, and of their rapid increase in number under mercurial treatment.

DEMONSTRATIONS.—Dr. ELSCHNIG (Gratz) demonstrated a case of Brooke's so-called *Epithelioma adenoides cysticum* as a *Hæmangioendothelioma tuberosum multiplex*, according to the views recently expressed by Prof. Jarisch.

Prof. JARISCH demonstrated (1) a case of *Darier's disease* with the supposed Psorospermia.

(2) A peculiar eczematoid ulcerating eruption on the right ear, and in its neighbourhood in a middle-aged man. The outlying lesions, although of vesicular appearance, were solid, and microscopically were found to be *Ulcerating Colloid Milium*. Many of those present diagnosed the lesions as syphilitic.

(3) A young man with deep blue erythema of the nose and ears with much infiltration, and large subcutaneous nodules on the hands, feet, arms, and buttocks. Microscopically, the nodules consisted of masses of epithelial cells like lupus, but with few giant-cells. Although the idea of a multiple sarcoma was considered, the balance of opinion was in favour of a cutaneous tuberculosis of the type known in Paris as *Lupus pernio*. [I have seen no case of *Chilblain Lupus* in this country present the same intensity or wideness of distribution.—J. J. P.]

(4) A typical case of *Hydroa vacciniforme* in a young man.

(5) A beautiful example of *Hydrocystoma* of twenty years' duration in a woman aged 58, which accorded in all its characters with those recorded by Jackson, Robinson, Hutchinson, Adam, Napier, &c. Although no doubt was thrown by the exhibitor on the accepted pathology, he had made five hundred sections without demonstrating the excretory ducts.

(6) A cretin male, aged 56, with very numerous and large *Myomata* of the left cheek and forehead, which had existed all his life.

At the final general meeting it was unanimously resolved to hold no meeting in autumn of next year owing to the Third International Congress of Dermatology to be held in London. J. J. P.

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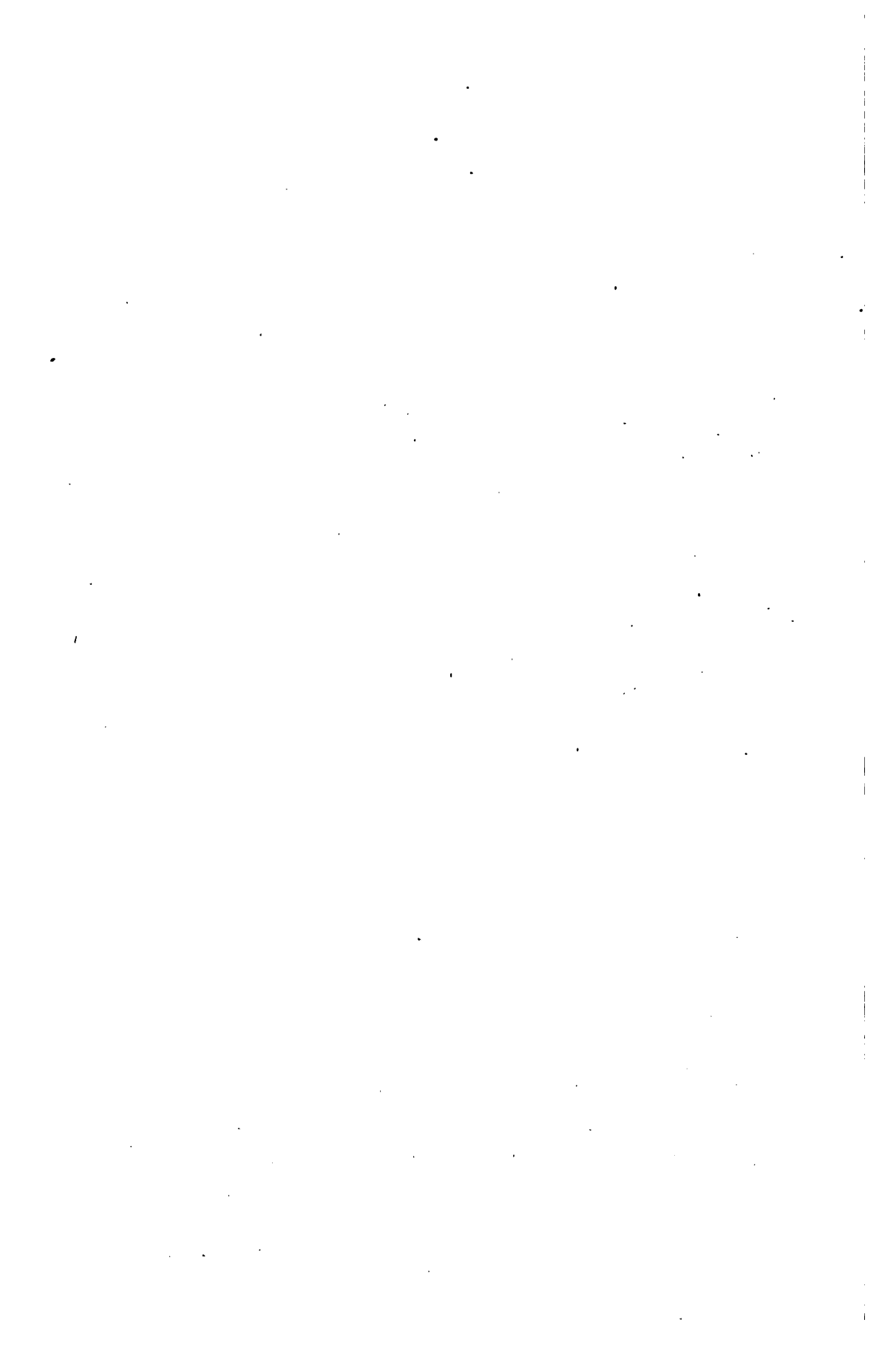
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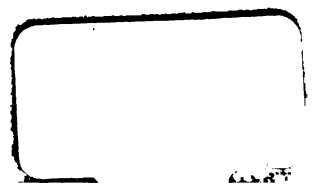
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